Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) SIVE Spring

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Hours | Min. | (Month, Day, Examiner 307 Cranberry Montgomery rrace Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months 042-14-3146 New Haven, CT Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Montgomer 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 209 errace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Dres 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ White 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Iruckina anage ( 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) aca omenic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel

t Cremation Services Perry Hall mb 21128 20c. Location - City or Town, State Edward Mazzetla Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 17-8-2008 Forest Hill, mb 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services
8500 Harford Rd Parkville MD 21234 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗌 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 Z No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☑ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident 1 □Yes 2 □No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Iweedt 18111

DHMH 17 Bev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 22

2008

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- For Amend #30 per DVR, G881 7/23/08 TTT Cate of Death

Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** RANCIS MC QUADE 10:10 AM 2000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HARBOR HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☑ M 2 □ F 216-14-7726 Yrs. Director Dec 22. 1923 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" ~ :: any injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Ves 2 □ No Director N/A Marvland Baltimore 3 8 1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1234 Patapsco St., Apt. 4 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ∐Yes 2 🛣 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No Specify: δ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Corp. Crane Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Beulah E. Whitten John McQuade ဥ 19a. Informant's Name/Relationship (Type. Print) Elizabeth J. Bohlman (Niece) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2056 Bandy Avenue, Eldersburg, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State New CAthedral Cem. 7/23/2008 Baltimroe, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address C Faculty Rallon Home, P.A. McCully Polyniak Funeral Home, P.A. 21230 21. Signature of Funeral Service Licensee Kevin E Ecker 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK SEVERE 1 DAY **Physician** disease or condition resulting in death) ) /Medical Due to (or as a consequence of): **Examiner** 1 DAY METABOLIC ACIDOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is it is a second to the cause). Due to (or as a consequence of): by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and ise as the burial-transi PNEUMONIA that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, NEUTROPENIA, FEBRILE S: CO WAMOUS IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent premant in the past 12 months?
1 ☐ Yes 2 ☑ No 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, CATARACTS 1 Yes 2 No 3 Probably 4 Unknown THROMBOCYTOPENIA Be Completed ACUTE RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION 24a. Was an autopsy performed? HYPOCALCEMIA 2 **N**0 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled in Co 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number RES ØØØ 1 HOUSE OFFICER 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Dennis Termulo,

31. Date filed (Month, Day, Year)



MD Harbor Hospital Baltimore, MD

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ames i. Menov		For State		int of Health a ite of Death	and Mental n	rygierie Reg.	No. 200	8 2350
Physicia	n/	Registrar  1. Decedent's Name (First, Middle,Last)				2. Date of Death		3. Time of Death
ledical Examir	ner	James Thomas  4a. Facility Name (if not institution, give street and numb			, or Location of Deat	July 18, 200	8 4c. County of Death	2130 hrs
}		Walnut Street Pond		Manches	ter		Carroll	
Funeral Director		212-92-4402 1XM 2F	Age (In yrs. last birth		Year If Under 24Hr Days Hours Mir		MM/DD/YYYY) 9. Birt Foreig 1970 Cor	
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
faryland 28a-f show	ō	Penn. York	На	nover				1 Yes 2 X No
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene.  Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho rother traumatic event, the Medical Examiner must be notified at once.	Director	10e Street and Number 1406 Wanda Dr.			7331		Citizen of What Cour	ntry?
ath wit	Funeral	11. Marital Status  1 Never Married  2 Married  Armed Force	es?	<ol><li>Was Decedent of If Yes, specify Cu</li></ol>	Hispanic Origin? ( S ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	<ol> <li>Race - Ameri White, etc.</li> </ol>	can Indian, Black,
fter de		3 Widowed 4 Divorced If Yes, Give Year	2X No	1 Yes 2X	No specify:		Specify:	White
nours a	ed by	or Dates: 15. Decedent's Education (Specify only highest grade of	d	ecedent's Usual Occu			6b. Kind of Business/I	ndustry
21215-0036 and be filed within 72 h Mental Hygiene. marked other than "r c event, the Medical E	Completed	Elementary/Secondary (0-12) College (1-4	or 5+)	Estimato	r		Moving C	ompany
21215-003 uld be filed withi Mental Hygiene, marked other tt	Be Co	17. Father's Name (First, Middle, Last)  James Thomas Merrow,	Jr.			e (First, Middle, Mai	eth Cook	e
2121; hould be fill and Mental I is marked rtic event,	10 B	19a. Informant's Name/Relationship (Type, Print )		. Mailing Address (S	1		er, City or Town, State	
e, MD 2  1 and 2 shou  Health and N  item 27 is n  r traumatic		Marcie E. Merrow - mo	ther 4	00 Glenv	ille Rd.	Hanove Date 12	r, PA. 1	7331
Baltimore, Morenit., Pages 1 and 2 Department of Health Important: If item 2 nijury or other traum		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from	State cremato	Disposition (Name of ry or other place)			20c. Location - City or Baltim	
Baltimo permit., Pag Department Important: injury or ot		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	116610					Chapel P.
	4	J. Sant Elland		3296 Ch	armil Dr	. Manch	ester, M	D. 21102
Physician /Medical		23a. Part I. Enter the disease, or complications that caus failure. List only one cause on each line.		enter the mode of dy	ing, such as cardiac	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and Death
kaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a co						- Boati
		Sequentially list conditions, b						
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	ensequence of):	-2104				
nd ransit	Exar	events resulting in death) Last  Due to (or as a co					1.00	
760, Trate be executed physician and the burial - transit	Medical	X UNPENDED AMENDED	23a,27,28	Ba-f, perM	E, g881 7	/31/08 TT		
376C	Me	3b. Was decedent pregnant in the	come of pregnancy	Fetal death	3 Ectopic pregr	nancy	23d. Date of deliver	y Day Year
Vision of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate batter death.  Director: After this certificate has been signed by the attending physicii in by the funeral director, page 2 should be detached for use as the buril.	Physician/	past 12 months?	t at time of death 5					say roa
Division of Vital Records, P.O. E go or Attending Physician: The law requires that the d is after death.  al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached.	<u>a</u>	Part II. Other significant conditions contributing to de	eath but not resulting	in the underlying cau	se given in Part I.		acco use contribute to	the cause of death?
ds, require	Completed					24a. Was an		topsy findings available
e law te has l	du					autopsy perform 1 ✓ Yes 2	ed? death?	completion of cause of
ital Recician: The scertificate rector, page		25. Was case referred to medical		26.P	lace of Death (Check		NO 1 V	2 110
Vita hysici this co	To Be	1 1 165 2 110	the same of	tpatient 3 DOA		ing Home 5 R	esidence 6 🗸 Othe	r: Scene
n of ding Ph h. : After	<u></u>	27. Manner of Death  1 Natural 5 Pending 28a. Date of (Month, Discourage)		FNd	Injury at Work? Yes 2 X No		entered po	end and
Atten	cati	2 X Accident Investigation 28e Place of	08 Fnd 10:	m, street, factory, offi		drowned 28f. Location (Str	eet and Number or Ru	ural Route Number, City
ours after Dir	Certification:	3 Suicide 6 Could not be determined (Specify) 1		,	g,	or Town, Sta	te)	nchester, M
the Fu	Medical C	29a. Certifier (Check only one) 2	examination and/or in	th occurred at the time vestigation, in my opin	e, date and place, an nion, death occurred	d due to the cause( at the time, date ar	s) and manner as stated place, and due to the	ed. ne cause(s)
P N S S	Be	29b. Signature and title of certifier		29c. Lic	cense number OC	ME :	29d. Date signed (Mo	nth, Day, Year)
		Theodor M. King Ja.	. Com	0.	.C.M.E.		July 19, 2008	
Ø		30. Name and address of person who completed cause Theodore M. King, Jr., MD. Assistant	of death (Item 23a) Medical Exami	ner 111 Penn	Street, Baltimo	re, MD 21201		
Sta		31. Date filed (Month, Day, Year) 32. Regis	strar's Signature	wes				
Regist	वा	JUL 2 2 2008 Salana	~					

08-05460 Igor Mayyer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 23504

,o. mayyor	1- For State Registrar	Certificate of Death	Reg. N	o. 2000 2000
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last)  IGOR	MAYYER	2. Date of Death Month Day July 16, 2008	3. Time of Death 0905 hrs
Kr. V	4a. Facility Name (if not institution, give street and number) 4900 Battery Lane Apt. 211	4b. City, Town, or Loca Bethesda		4c. County of Death  Montgomery
Funeral Director	,	Months Days	Under 24Hrs. 8. Date of Birth (M	M/DD/YYYY) 9. Birthplace (State or Foreign Country) UKRAINE
	Usual Residence of Decedent		1 04/03/	10d. Inside City Limits
nd show any ice.	10a. State	Oc. City, Town or Location BETHESDA		1 Yes 2 X No
72 hours after death with the Maryland 17 hours after death with the Maryland 12 matural", or items 23a or 28a-f show al Examiner must be notified at once, leted by Funeral Director	10e. Street and Number 7620 OLD GEORGETOWN ROAD	10f. Zip Code 208		Citizen of What Country?
th with the tems 23a at the notion	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13. Was Decedent of Hispan If Yes, specify Cuban, Me	ic Origin? ( Specify Yes or No- exican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
s after death w ral", or items niner must be	3 Widowed 4 Divorced of Parks Sive Year or Dates:	X No 1 Yes 2 X No sp		Specify: WHITE
72 hours n "natur al Exam	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12)  College (1-4 or 5-12)	during most of working life, DC		o. Kind of Business/Industry
21215-0036 uld be filed within 72 hour Mental Hygiene. marked other than "natte event, the Medical Exa	17. Father's Name (First, Middle, Last)	PERSONAL TR	AINER Nother's Name (First, Middle, Maid	FITNESS INDUSTRY en Surname) CHERNOKOT
121; Id be fil dental F narked event, i	YURIY 19a. Informant's Name/Relationship (Type, Print )	MAYYER	LYUDMILA d Number or Rural Route Number	-UNKNOWN-
sho and 7 is	LYUDMILA MAYYER / MOTHER	3809 CLARKS LA	NE, APT. # <del>218,</del>	BALTIMORE, MD 21215
nore, Mages 1 and 2 ages 1 and 2 nt of Health tt: If item 2 other traum	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from Sta	20b. Place of Disposition (Name of cemete crematory or other place)  BALTIMORE HEBREW	,	REISTERSTOWN, MD
Baltimore, permit Pages 1a Department of He Important: If ite injury or other tr	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22. Name and Address of	Facility SOL LEVIN	SON & BROS., INC.
Physician	23a. Part I. Enter the disease, or complications that caused to failure. List only one cause on each line.	he death. Do not enter the mode of dying, suc	h as cardiac or respiratory arrest,	Between Onset and
/Medical xaminer		oxycodone intoxicati		. Death
Je Je	Sequentially list conditions, if any, leading to immediate Due to (or as a conse	quence of):		
red list Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  c.  Due to (or as a conse	quence of):		
execul an and al - tra	X UNPENDED 18 23	,19b per fhg881 <b>7-22</b> a,27,28a-f, perME, g8	-08 vt	
<b>2</b> ts 47 d ≥		e of pregnancy		23d. Date of delivery  Month Day Year
D. Box 68: the death certification is the attending the attending the by the attending by the signal in the signal	1 Yes 2 No 9 Unknown g Unknown	ime of death 5 Other (Specify)		
P.O. ss that the gned by the detache		but not resulting in the underlying cause give		cco use contribute to the cause of death?  2 No 3 Probably 4 V Unknown
Records, P.( The law requires that ficate has been signed to specificate has been signed to detect that the completed by			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
of Vital Records, ng Physician: The law require. After this certificate has been simeral director, page 2 should the		26.Place of	performe  1  Yes 2  Death (Check only one)	
f Vital Physician or this cert ral directo	examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatie	nt 2 ER/Outpatient 3 DOA	ner 4 Nursing Home 5 Re	sidence 6 Other: Scene
ision of Attending Ph ar death. ector: After t by the funeral		ry 28b. Time of Injury 28c. Injury and 1 Yes	28d. Describe how unk	Injury occurred
Division ospital or Attending nours after death.  meral Director: After filled in by the fune.  Certification:	Accident Investigation 28e. Place of Injury 4 Homicide Homicide (Specify)	ury - At home, farm, street, factory, office build cesidence	ding, etc. 28f. Location (Street or Town State Apt 211	net and Number or Rural Route Number, City  2) 4900 Battery Ln.  Bethesda, MD
2 E 2 E 3 L		knowledge, death occurred at the time, date nination and/or investigation, in my opinion, de	and place, and due to the cause(s	) and manner as stated.
To the complete of the complet	and manner stated.  29b. Signature and title of certifier	29c. License n	umber 2	9d. Date signed (Month, Day, Year)
	30. Name and address person who completed cause of d	O.C.M.	E	July 17, 2008
	Melissa Brassell, MD Assistant Medical 31. Date filed (Month, Day, Year) 32. Registrar		timore, MD 21201	7
Stat Registra	1111 7 7 711118 1999			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY Month **Physician** MOORE 2008 10:45 AM KART A ADELINE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE GILCHRIST HOSPICE CARE TOWSON Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/12/1953 7. Age (In yrs. last birthdav 5. Social Security Number **Funeral** Months Days Hours 1 □ M 212 F 54 NY **Director** 521-86-1623 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County I Hygiene. other than "natural" or items 23a or 28a-f show rent, the Medical Everniner must be notified at 1 ☐Yes 2√2 No Director RANDALLSTOWN BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 USA 4245 MARY RIDGE DRIVE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★□Yes 2 □ No AIR HYes, Give Year or Dates: FORCE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√□No Specify Specify: WHITE 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MEDICINE TOXICOLOGIST permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other thr any injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MOORE CYRIL ဂ္ JACK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4245 MARY RIDGE DRIVE RANDALLSTOWN, MD 21133 BARRY LEVINE / HUSBAND 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY 7/23/2008 OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Matt 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final do metrial **Physician** ilars disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) signed by the a d be detached f P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t irector, page 2 s autopsy performed2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the within 2

State Registrar 29b. Signature and title of certifier

JUL 2 2

BMC

29c. License number

29d. Date signed (Month, Day, Year)

6701 N. Charles St. Balto. and

and manner stated.

37: Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** MINIS 17th 2008 RAE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE SEASON'S HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN Date of Birth (Month, Day, Year) 12/05/1917 If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2 💢 F Months Days Hours 90 Director 072-12-0001 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Wedical Examinar must be modified at 1 □Yes 2 No Director OWINGS MILLS BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21117 3440 ASSOCIATED WAY, APT. 310 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, Ite Midtol Examinante. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: Ď 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTING BOOKKEEPER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGAN KAUFMAN JENNIE JULIUS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1439 WILLIAM STREET, BALTIMORE, MD MARSHA VITOW / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP: 07/21/2008 TOWSON, MD 4☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician intracranial /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the arriving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed ?4 hours after death. and Due to (or as a consequence of): After this certificate has been signed by the attending physician of funeral director, page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Ye ar Month Dav □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d, Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation s after dea. 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 🕮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier

Registrar

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

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2008

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and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

STREET

29c. License number

29d. Date signed (Month, Day, Year)

RETSTENSTOWN MD

08-05534 Andrew Perry Noel Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 23507

		For State		Certific	ate of	Death					Reg. No.				
Physician/		Decedent's Name (First, Middle,Last)								Date of Dea Month	ath Day	Year		ime of Death	
ledical Examine		Andrew Perry Noel								July 19, 2	2008			1510 hrs	
The same of the sa		a. Facility Name (if not institution, give	street and number)		4t	c. City, Tow Ellicott		cation of I	Death			County of De Dward	eath .		
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Funeral	5	Social Security Number 6. Sex	7. Age	(In yrs. last bir	triday)	Months	Days	Hours	Min.			Fo	reign Country	٨	1
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5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner		15. Decedent's Education (Specify on	y highest grade com	pleted) 16a		's Usual Od st of worki					16b. K	and of Busin	ess/Indu	stry	
22 ho 72 ho 26 ho 26 ho 27 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	5+)			_					Educa	+ <del>-</del>		- 1
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21215-0036 ould be filed within 7 Mental Hygiene. s marked other than ic event, the Medica		7. Father's Name (First, Middle, Last)			•					Paetzo		Surriante)			
be fi		Thomas W. Noel										ity or Town,	State 7	n Code)	-
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.  ant: If iten 27 is marked other than "natural", or items 23a or 28a-f 3the or other traumatic event, the Medical Examiner must be notified at once a contract of the contract of the Committeed by Europeal Director		19a. Informant's Name/Relationship (Ty										City,			- 3
<b>∑</b> 5 ± 5 ± 5 €		Valerie P. Noel/M	Juler	I .		ition (Name				Date		Location - Ci			-
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Baltimore, permit. Pages 1 an Department of Hea Important: If iter injury or other tra		21 Signature of Funeral Service Licen	ee 0	M01044		ame and A			Dat	ry H.	Witz	zke's	Fami	ly FH I	nc.
ದ ಶಾಸ್ತ್ರಕ್ಕ	_	Shem Collins- W	Ka		41	12 010	l Co	lumb	ia P	ike E	llico	ott C1	ty,	MD 2104 Approximate Intel	3 rval
Physician	7	23a. Part I. Enter the disease, or comp failure. List only one cause on ea	idations that caused ch line.	the death. Do	not enter th	ne mode of	dying, s	such as ca	irdiac or i	respiratory	arrest, sn	ock, of fleati		Between Onset a	
/Medical caminer	10		Multiple Injuries	5									_	Death	-4
· anime	- 1	or condition resulting in death)	Due to (or as a cons	equence of):									- 1		
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Box 68  e death certiff the attending ed for use as:	Sic	1 Yes 2 No 9 Unknown		t time of dodin	5 O	ther (Spec	ry)								
ires that the de signed by the	Physician	Part II, Other significant conditions	-	th but not resul	ting in the	underlying	ause g	iven in Pa	ırt I.	23e. Di	id tobacco	use contrib	ute to th	e cause of death	?
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Dital Dital Illed	Certification:	4 Homicide determine	(-)	ajor Road /											_
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Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examine	r:On the basis of ex and manner stated	amination and/	or investiga					t trie time, c					
F » F S	B	29b. Signature and title of certifier	1.			290		e number						th, Day, Year)	
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Y	ł	30. Name and address of person who	completed cause of	death (Item 23	a)				-	-					
5			ssistant Medica		111 F	Penn Str	eet, B	altimore	e, MD 2	21201					
Sta	ate	31. Date filed (Month, Day, Year)	32 Registi	rar's Signature	April	all B									
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Amend #9 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year Rosa Nollie 05:55 AM JULY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Union Memorial Hospital Baltimore 8. Date of Birth 12/193. Birthplace (State or Foreign (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days 128-26-9980 1 □ M 2×5xF Hours 77 Director VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f shov Examiner must be notified at 28a-f show Baltimore 1 √ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4001 Clarks Lane Unit 414 21215 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2√ENo δ Specify: Black 3 Widowed 4 Divorced "natural" Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) health care hospital other 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) William A. Meredith Anna P. Moore ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 ls Joseph Nollie / Husband 4001 Clarks Lane Unit 414; Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of I-Important: If ite any Injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Woodlawn Cemetery 07/25/2008 Woodlawn, Maryland 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licenses 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Helatorenal syndrome hours /Medical Due to (or as a consequence of): Examiner Circhosis years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner years The law requires that the death certificate be executed attending physician and for use as the burial-transit Hebatites C Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 📉 No 3 Probably 4 Unknown Completed this certificate has been s al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 1 Sinpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dif 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Beginangalom MO AT 2438946

State

altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

MEMORIAL HOSPITAL

UNION

MD, 32. egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SASIMANGALAM

N

31. Date filed (Month, Day, Year)

JULY 20,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item tale per Mary was 2008/05/08 the least hand Mental Hygiene Amend Items 25,27,28a-f,23acparione 07/23/08dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month July Charlotte S. 0'Keefe 2008 8:50 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kline Hospice House Mt. Airy Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month) Day, Year, 1913 Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** New York 1 M 2 X F 95 Yrs **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 ☑ No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2568 Bear Den Road 21701 United States of America Funeral tems 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: Specify: White à 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House Wife Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: if item 27 is marked other t any Injury or other traumatic event, In. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Sobetzer Harriet Beeman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David G. O'Keefe (Son) 21 Park Ave., Babylon, New York 11702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. 07/15/08 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, MD 21228 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 21. Signature of Funeral Service Licenses M00333 | 8728 Liberty Road, Randallstown, MD. 21133-4784 1. Enter the dis. ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Subdural Hemotema /Medical Due to (or as a consequence of) CERTIFICATION ASPROVED BY MEDICAL EXAMINES Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of) Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Vascular 57 YOISE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform of Vital 1 ☐Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1□Xes <del>2XN</del>o Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation Alatural after death.

Director: Al Subject fell and hit head on 07/04/2008 Unknown™ 1 ☐Yes 2 No 2 Accident 3 Suicide tollet
28t. Location (Street and Number or Rural Route Number,
City or Town, State)
2568 Bear Den Rd. 6 Could not be determined Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Home Trederick, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check on one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

Thomas

Horen

Year

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William James Owens 7 2008 11:15p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Summit Park Health Rehabilit If Under Cat Physicial List Baltimore Co. Date of Birth (Month, Day, **Funeral** 1 XM 2 ☐ F МD 54 53 12 10 Director 219-60-6896 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shor Examiner must be notifled at MD N/A Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18 Mardrew Road 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: "natural", or 1 ☐ Yes XXXNo Specify. Specify: Black 2 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Disabled 10th Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked ot William Boyd Owens Marian Ebert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trainonce. Elizabeth Fenner-sister 18 Mardrew Rd. Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Murial 2 ☐ Cremation Baltimore Cem. 7/25/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST 1101 E. North Avenue Baltimore, MD 21202 ) a 0~ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SIXMONTH TASTATIC LUNG Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of)

**Physician** /Medical **Examiner** The law requires that the death certificate be executed and burial-trai physician Physician/Medical the as attending use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be Certification: To funeral filled in by the

with the Maryland

death

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

show

				performed? death? 1 Yes 2 No 1 Yes 2 No	
25. Was case referred to medical			26. Place of Dea	th (Check only one)	
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DOA	Other: 4 Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident investigati		28b. Time of lnjury M	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ome, farm, street, factory, off	fice	28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a Certifier 1 Certifying	hysician: To the hest of my kno	wledge, death occurred at the	he time, date and place	and due to the cause(s) and manner as stated	

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) nd manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

7,008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

avaino Mi)

31. Date filed (Month, Day,

32. Registrar's Signature

within 2

Medical

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 7:45a м 18 **Physician** July 2008 Hakon Olsen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Stella MAris Hospice Towson Baltimore 8. Date of Birth (Month, Day, Year)
Oct. 22, 1924 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F 112-18-6691 83 Norw av **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show 1 ☐Yes 2X No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, Ihe Medical Examinant be morified. and once. Director MD Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 349 Savannah Road 21221 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1★JYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: White ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer NKNO WOOD 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harald Olsen Olivia Ellevold ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Liselotte Olsen /wife Savannah Road Baltimore MD 21221 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 7/21/08 Gardens of Faith Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave, Balto. MD 21. Signature of Juneral Service Licensee Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine sician and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician sthe burial Physician/Medical attending p IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No Hospital or Attending Physician: after death.

Director: After this certification by the funeral director, page 100 miles. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \mathbb{X} \) Other (Specify) \( \mathbb{HOSPICE} \) 1 ☐ Yes 2 😿 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide e Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

DR. ERNESTINE WRIGHT

2008

**JUL 22** 

31. Date filed (Month, Day, Year)

7:45

2008

18,

HAKON OLSEN

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

3 Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician 7:45 PM Paulomi J. Patel JUI 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agnes Baltimore N/A HOSDUTA f Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) July 27, 1 Birthplace (State or Foreign Country) Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** 1 □ M 2 😾 F Days Hours 213-72-2382 55 Yrs India **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanties must be notified at 1 ☐ Yes 2 No Director Baltimore Catonsville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 USA 14 Nayborly Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Asian ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bipinchandra Patel Jayshree Patel ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jagdish K. Patel, Husband 14 Nayborly Court Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or oti once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 07/23/08 Baltimore, Maryland 21. Signature of Funeral Service (Consee Thomas Gregor 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final CerebroVaseular **Physician** disease or condition resulting in death) /Medical Examiner Hy pertension quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (or as a consequence of): Examiner and I-transit death certificate be executed that initiated events resulting in death) Last burial-t Due to (or as a consequence of): PAULOMI PAILL Division of Vital Records, P.O. Box 68760, physician at the burial Physician/Medical s been signed by the attending I should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has tuneral director, page 2 s autopsy performed? 1 □ Yes 2 ☑ No 2 **1**00 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: A completely filled in by the f 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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State Registrar

29b. Signature and title of certifier

20556

29c. License number

29d. Date signed (Month, Day, Year)

MD of person who completed cause of death (Item 23a) (Type, Print)

. Caton Ave Baltimore MD

32 Registrar's Signature

0-0009	Please Type of Philit in Black indelible link. Elistie All Copies Are Legible.		
Omar Kenyatta Phillips	State of Maryland / Department of Health and Mental Hygiene	2008	2351
1- For State	Certificate of Death Reg. No.	2000	2001
Registrar	Tog: 100		

Physician/ I Examine	_			Cert	tificate of				al Hyg		eg. No.	_	000	2351
Lanciti	,	Decedent's Name (First, Middle) Omar Ken		hillips						Date of Dea Month July 19, 2	ith Day	Year		e of Death 30 hrs
	4	a. Facility Name (if not institution University Hospital			4	b. City, Tov Baltimo		cation of	Death		40	N/A		
Funeral Director	- 10	218-13-2068	6. Sex	7. Age (In yrs. Ia	st birthday) Yrs.	If Under		If Under Hours	24Hrs. Min.	8. Date of Bi		/DD/YYYY) 1972	9. Birthplace Country)	(State or Foreign
d how any re.	1	Usual Residence of Decedent 10a. State 10b. County 10b. County	N/A		Town or Location									rside City Limits Yes 2 No
the Maryland a or 28a-f show tified at once. Director		0e. Street and Number 3329 Card	enas Av	enue		10f. Zip Ci	ode .213	3			10g. Cit	izen of Wha		
death with or items 23s must be not	Laurera	11. Marital Status 1 Never Married 2 X M 3 Widowed 4 Div		2 <b>X</b> No	If Ye	Decedent es, specify (	Cuban, N	Mexican, I		ify Yes or No can, etc.)	0-	14. Race - White, Specify:	American Indetc. Blaci	
MD 21215-0036 2 should be filed within 72 hours after h and Mental Hygieria T's marked other than "natural", c matic event, the Medical Examiner 1 TO Be Commissed by E	Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)	cify only highest gr		16a. Decedent	's Usual Oo st of worki	ccupation	n (Give ki			16b.		iness/Industry	
ID 21215-0036 should be filed within 72 and Mental Hygiene. 7 is marked other than matic event, the Medical	2	12th 17. Father's Name (First, Middle Grego	ry	/A L. Ph	illips	ipl <u>o</u> y	18		Phy]	irst, Middle,	E	Surname)	hilli	
nore, MD 21.3 ages I and 2 should bent of Health and Men nt: If item 27 is mar rother traumatic eve	2	19a. Informant's Name/Relations Nicole Phi	ship (Type, Print)	ife	19b. Mailing	Address Car	den	and Numb	er or Ru Aver	ral Route Nu	mber. (	imor	e, State, Zip C e, MD City or Town,	21213
Baltimore, ME permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		20a. Method of Disposition  1 XXBurial 2 Crematio  4 Donation 5 Other S	pecify:	from State	rematory or oth	er place)	n <b>.</b>		7/2	24/08		Balt	imore	MD
Departing Children (1975)	-	21. Signature of Funeral Service  Lodu  23a. Part I. Enter the disease, 8	r complications that	caused the death.	11	LO1 E	E. N	ort	h At	renue	Ва	ltim	rt App	EAST MD 2120  roximate Interval ween Onset and
Medical _xaminer		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	a. Gunshot	Wound(s) of t		d Torso								Death
sit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	s a consequence of										
be executivities and and urial - tra	glical	UNPENDED	d AMENDED	)										
Box 68760  e death certificate be the attending physical for use as the butter for the butter fo	clan/I	IF FEMALE: (3b. Was decedent pregnant in the past 12 months?)  1 Yes 2 No 9 Ur	the 1 Live	s, outcome of preg e birth egnant at time of de known	2 Fe	tal death her (Speci	3 [	Ectopic	pregnan	су		3d. Date of Month	delivery Day	Year
ires that the de signed by the 1 be detached i	음	Part II. Other significant condi	tions contributing	g to death but not re	esulting in the u	inderlying o	cause giv	ven in Par	rt I.				bute to the ca	use of death?
Vital Records, hysician: The law require this certificate has been si director, page 2 should be a conditional for the conditi	Completed										opsy formed	?		findings available tion of cause of
f Vital Physician: er this certi ral director	9 Re	25. Was case referred to medic examiner? 1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1	Inpatient 2	28b. Time of	3 DC	A C	of Death ( Other at Work	Nursing	Home 5 28d. Describ	e how i		Other:	
DIVISION To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident Inversion 3 Suicide 6 Con	estigation uld not be	inth, Day Year) 8, 2008 lace of Injury - At h		et, factory,		es 2 🗸	No i	28f. Location or Town	(Stree	t and Numbe	er or Rural Ro	ute Number, City
To the Hospii within 24 hou To the Funer completely fill	ल	29a. Certifier 1 Certifying	Physician: To the bas	pest of my knowled is of examination a	ge, death occu	rred at the t	time, dat opinion,	te and pla death oc	ce, and courred at	due to the ca the time, da	use(s) te and p	and manner place, and d	as stated. lue to the caus	se(s)
wi vi	Me	29b. Signature and title of certif	and manne	ы экақсу.			O.C.N	number /I.E.				d. Date sign	ed <i>(Month, Di</i>	ay, Year)
$n_{j}$	-	30. Name and address of person Pamela E. Southall,	MD Assistar	ause of death (Item of Medical Exa Registrar's Signal	miner 11	1 Penn	Street	, Baltim	ore, M	D 21201				

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For	Please				artment of F		•		_	ole.	
		1 - State Registrar				Ce	rtificate of	Death		Reg.	No. 2	0.8	23514
Physic		1. Decedent's Name <i>(Firs</i> Robert G						-	2. Date o Month Jul		Day 1.7 2	Year 2008	3. Time of Death 9:40 p.M
/Medi Examir		4a. Facility Name (If not in			mber)		4b. City, Town, o	r Location of		<del>-</del>	4c. County		9:40 β.
		Gilchris	t Nur	sing Cen	ter		Towson	1			Balt	imor	e
Funeral		5. Social Security Number	f 6.	Sex 11☑M 2□F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month	ı, Day, Ye		9. Birthp Coun	lace (State or Foreign try)
Director		213-32-2403 Usual Residence of Dece			73	110.			Apr.	27,	1935	Mar	yland
ryland how		10a. State 10b.	County		10c. Ci	ty, Town or Lo	ocation					1	0d. Inside City Limits
e Ma 8a-f s	Director		Balti	more		Dundalk							1 □Yes 2 □ <b>Xi</b> o
a or 2		10e. Street and Number					10f. Zip Code			10g.	Citizen of W	/hat Coun	try?
ns 23	Funeral	1700 Evergre	een D		edent Ever in U	S 13	Was Decedent of F		in? (Specify Vos o		nited		es an Indian,
ifter d	ᇤ	1 ☐ Never Married 2	Married	Armed Fo	rces?		If Yes, specify Cuba	an, Mexican,	Puerto Rican, etc.	)		k, White, 6	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Markal Expredient roust be notified at once.	d by	3 ☐ Widowed 4 ☐ D		If Yes, Gi Year or D	ates	957 <b>-</b>	1 □Yes 2X No	Specify:			Specify	Whi	te
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Venta Venta rked tic ev	To B	William Pac	iocco					There	esa Hele	n Jui	lian		
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Department any i		21. Signature of Pangrai	Service Ed	101/1	mell	//   [	ouda-Ruck	Funera					
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/Medical Examiner		resulting in death)		aDue to	or as a conseq			, ,	-				70017113
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be executed ician and burial-transit	Examin	that initiated events resulting in death) Last		c Due to	or as a conseq	juence of):							
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the d	ysic	1 □ Yes 2 □ No 9 □ Unknown		9 Unkn		ueaii 5[	Other (specify) _						
The law requires that the death certificat te has been signed by the attending phyage 2 should be detached for use as the	by Pl	Part II. Other significant		- I		ulting in the u	nderlying cause giv	en in Part I.	23e. I	Did tobac	co use conti	ribute to th	ne cause of death?
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sician; The law s certificate has t irector, page 2 s	O								1 □ Y	performed	<u>1</u> 2   ∂	death?	2 □No
siciar certil	o Be	25. Was case referred to examiner?	medical	Hospital:			Oth	or:	of Death (Check o				100:000
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ath. rath. r: Aft	atio	1 🖾 Natural 5 🗆 2 🗆 Accident	Pending investigation		th, Day, Year)	Injury		k? Yes 2 □ No	o				
I or Attending Physician; after death. Director: After this certifica d in by the funeral director, p	Certification	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not determine	4   28e. Place	of Injury - At he	ome, farm, str	reet, factory, office		28f. Location City of	on (Stree r Town, S	t and Numb tate)	er or Rura	I Route Number,
pltal		29a. Certifier	`artifying E	hyeician: To the	heet of my kno	auladae deat	h occurred at the ti	mo data and	place and due to	the equa	10(a) and me		tatad
To the Hospital or Attending Physician: The I within 24 Hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ledical		Medical Exa	miner: On the b	asis of examina ner stated.	ation and/or in	exestigation, in my o	pinion, death	n occurred at the t	ime, date	and place,	anner as s and due to	taled. the cause(s)
Vithi Vithi Com	M	29b. Signature and title of	certifier	m()			29c. Licens	e number	0	29d.	Date signed	(Month,	Day, Year)
1		The state of the s						0 36		0	שולוט	3100	21204
0+1		30. Name and address of	7. CX	AARUES	MO	6/01		halle	5 ST 7	100V-	YON	MD	21204
Sta Registr		31. Date filed (Month, Day	2 200	32. R	egistrar's Signa	ature							
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 9881 7-29-08 vt. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 23515 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month John R. Price Jr. 3. Time of Death Year

/Me	dical	JOHN R MIC				07	15 200	8 0049 AM
	niner	4a. Facility Name (If not institution, give street and num	nber)	4b. City, Town, or	r Location of Death	1	4c. County of D	eath
		UNWERSIAN OF MARYLAND	MED CENTE	L BALTI	MORE		n/a	
Funer	ai		7. Age (In yrs. last birthd	(ay) If Under 1 Year		8. Date of Birti		Birthplace (State or Foreign
Direct		217-46-0750   ¹☒м 2□F	48 Yrs	Months Days	Hours Min.	0ct 15	1959 Ms	Country)
		Usual Residence of Decedent	10		1	1000 15	1737 116	iryranu
dand ow		10a. State 10b. County	10c. City, Town or	r Location				10d. Inside City Limits
Man)	ğ	Maryland Baltimore	m4					1 ∐Yes 2 🙀 No
the ?	Director	Maryland Baltimore  10e. Street and Number	Timo	onium			40 - Citizen of Mines	
vith or	ᄚ			10f. Zip Code			10g. Citizen of What	Country?
ath v	<u>a</u>	3 Athenry Court		2109			USA	
r de	Funeral	11. Marital Status 12. Was Dece	dent Ever in U.S. 1	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	lispanic Origin? (S an. Mexican. Puert	pecify Yes or No- o Rican, etc.)	14. Race - A	American Indian, /hite, etc.
afte afte	II.		2 X No	1 □Yes 21X No	Specify:		Specify:	
5-UU36 72 hours after death with the Maryland natural", or Items 23a or 28a-f show lital Exeminer must be availised at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Da	ites:					White
5 E E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. De	ecedent's Usual Occup	ation	kina	16b. Kind of Busine	ess/Industry
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lan Id be lental ked o	일	John Richard	Price, Sr		Jov	Louis		Clark
Tary 2 shou and N is mar	-	19a. Informant's Name/Relationship (Type. Print)		ailing Address (Street				
Ma d 2 s th au 7 is trau								
re, Maryls s 1 and 2 should if Health and Mer item 27 is marke other traumatic		Joy L. Price/Mother  20a. Method of Disposition		Athenry Co		Onlum, M	lary Land  20c. Location - City	21093
O 65 0 1-		1 X Burial 2 ☐ Cremation 3 ☐ Removal from S	State cemetery, c	sposition (Name of crematory or other place	(e)	Date	200. Location - City	or rown, state
Pa men ant:		4 □ Donation 5 □ Other (Specify)		e Cemetery	7/2	3/08	Parkton,	Maryland
<b>Baltimo</b> permit. Page Department Important: If	ġ	21 tre of Juneral Tric ycensee	)	22. Name and Addre	ss of Facility	E D	1 77 - 1	1 T
D SSE	ā	Bryan V. Clary		10 W. Pad	onia Roa	me or Du d. Timon	ijaney val ijum. Marv	ley Inc. land 21093
		23a. Part 1 Inter the disease, or compli ations that	used the death. Do not					Approximate Interval Between
Division		sho k, or heart fillure. List only one cause on						Onset and Death
Physicla /Medica	_	resuluni a di dealini	JO- PULM	UNAKY AK	KEST			IMMINENT
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ed sit	Examiner	cause. Enter Underlying	or as a consequence of):		6	1 After	CAL EXAMINEN	36 HRS 36 HRS
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ng p	Şe Ç	IF FEMALE:				_		
<b>BOX</b> ath cer attendir or use	2	23b. Was decedent pregnant 23c. If yes, outc	come of pregnancy irth 2 Tetal death	3 ☐ Ectopic pregnanc			23d. Date of	
the death certific by the attending pached for use as	<u>i</u>	1 DVos 2 DNo 4 Pregn	ant at time of death	5 Other (specify)			Month	Day Year
the do	hys	9 Unknown 9 Unknown	wn					
	0	Part II. Other significant conditions contributing to de	ath but not resulting in th	e underlying cause giv	en in Part !.	23e. Did to	bacco use contribut	e to the cause of death?
OT VICAL RECOIDS, P.O. BO Physician: The law requires that the death this certificate has been signed by the atter al director, page 2 should be detached for u	d by	RIGHT PNEUMOTHORA	C			1 🗆 Y	′es 2 <b>X</b> No 3⊑	Probably 4 Unknown
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DIVISION OF VITCAL IN To the Hospital or Attending Physician: The within 24 Hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	(Check only one)  2 Medical Examiner: On the base and mann	asis of examination and/o	or investigation, in my o	opinion, death occu	urred at the time,	date and place, and	due to the cause(s)
omp	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed (M	lonth, Day, Year)
	-	Colorado Do		18715	753905		/	2008
7		TO STATULE HO					1/10/	
10		30. Name and address of person who completed causi		pe, Print) ENE ST E	MITTMOS	FAG. 3	21201	
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State Registrar 31. Date filed (Month, Day, Year)

JUL 2 2 2008

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1753 PM 07 RIVER S 2008 MND /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NIA ALTIMORIE SECURS HOSPITAZ 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs **Funeral** 5. Social Security Number 219-38-613 1 1 M 2 □ F Months Days Hours Min. outh arolina **Director** Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the "Nacical Exercitor rust be notified at 1 Xyes 2 □ No Director 10g. Citizen of What Country? # 10e. Street and Number 10f. Zip Code 2 should be filed within 72 hours after death with 1 1 and Mental Hygiene. Is marked other than "natural", or items 23a or ? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: ٥ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industr (Give kind of work done during most of working life. DONOT use retired) Elementary/Secondary (0-12) Colleg (1-4or 5+) isto a 16 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev ပ De 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 84 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) onsville 21. Signature of fundral Service License 22. Name and Address of Backo Approximate Interval Between Onset and Death 23a. Park—Epfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immedian Cause (Final disease or condition resulting in death) Physician かく 2 s a consequence of): /Medical Examiner Seps Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequent of): law requires that the death certificate be executed burial-trans and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown signed by t t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ፩ 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe The 2 1 ☐ Yes e Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Linpatient 2 ER/Outpatient 3 DOA Certification; To funeral ( 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

BALTIMUPE ST

BATIMONE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

the Worcohmi 1 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20a-b, perFH, G881 7/24/08 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month ROSECLAIRE 2:27 PM ROBINSON JULY 2008 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 8 / 3 - 57 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 138-58-8205 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exeminar must be notified at Baltimore 1 Nes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? allaways USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Step Elementary/Secondary (0-12) College (1-4or 5+) Sroker 12th Grade years Pages 1 and 2 should be filed v ment of Health and Mental Hygie ant: If Item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore 3600 Callaway Kobinson Derrick HVENUE Department of Heal Important: If Item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or chest place) 20a. Method of Disposition Date 20c. Location - City or Town, State 155 Surial 2 X Cremation 3 ☐ Removal from State 07-23 -08 4 Donation 5 Other (Specify) 2140 North Fuiton Avenue 22. Name and Address of Facility Baltimore Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** INFARCTION BRA2N STEM disease or condition resulting in death) /Medical Due to (or as a consequence of):

ENCEPHALOPATHY Examiner Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): the attending physician and for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. 1 □ Yes 2 □ No. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JULY, 18, RES 000 JOHN KOTTARTHZE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S0074 BALTZMORE, MO HANOVER STREET, 31. Date filed (Month, Day, Year) Registrar's Signature State 2008 Registrar

			1 - State Registrar	Certificate of		ai mygieni Reg. N	Z II II X Z 13 I 0
	Physici		1. Decedent's Name (First, Middle, Last)  Emma Y. Rice			ate of Death	ay 1000 200 OLM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  MARY/AND GENERAL HOSP + Fall	4b. City, Town, o	r Location of Death	4	c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birt 216–28–8961	thday) If Under 1 Year Months Days	If Under 24 Hrs. 8. D Hours Min. (A	ate of Birth Month, Day, Year 3 28 2	9. Birthplace (State or Foreign Country) NC
	/land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	e Mary 3a-f st	Director	MD N/A Bal	ltimore			1 Kg Yes 2 □ No
	with th	Dire	10e. Street and Number	10f. Zip Code		10g. C	citizen of What Country?
	ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	212	LT/ Hispanic Origin? (Specify Y an, Mexican, Puerto Rican	res or No-	USA  14. Race - American Indian,
5-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Pedical Examinant be rediffed at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give Year or Dates:	If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	an, Mexican, Puerto Rican Specify:	ı, etc.)	Black, White, etc.  Specify: Black
-6	in 72 h "natu	Completed	(Specify only highest grade completed)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of working	16b. I	Kind of Business/Industry
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Maryland	2 should and Mer is marke aumatic	은	Luco Faines  19a. Informant's Name/Relationship (Type. Print) 19b.	Mailing Address (Street	Emma		r or Town, State, Zip Code)
ğ,	d 2				on Road Ba	-	
Baltimore,	permit. Pages 1 and Department of Heali Important; If item 2 any Injury or other once.		20a. Method of Disposition 20b. Place of cemeter	Disposition (Name of ry, crematory or other place		20c. I	Location - City or Town, State Randallstown MD
Bail	permit. Departi Import any Inj		21. Signature of Funeral Service Licensee	22. Name and Addre	ess of Facility MARCH North Aver	FUNER	RAL HOME-EAST timore, MD 21202
J ,09780	certificate be executed having physician and less as the burial-transit	Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Squartially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the conditions of the conditions of the conditions of the cause) and the cause of the conditions of the conditions of the cause of the conditions of the cause of t	enctive.	Sleep Ap	nea cy Di	Approximate Interval Between Onset and Death
O. Box	death e atter d for u	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☑ No  9 ☐ Unknown  23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death  4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	gy		23d. Date of delivery Month Day Year
ecords, P.	law requires that the d as been signed by the 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause giv	ven in Part I. 2		o use contribute to the cause of death?
паі жесс	The lar ate has page 2	Completed				24a. Was an autopsy performed? □ Yes 2 ☑ N	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
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ס ר	ig Phy ter this neral d	n: To	27. Manner of Death 28a. Date of Injury 28b. T	itpatient 3 DOA Offi Time of 28c. Injury	ry at 28d. [	Describe how inj	
DIVISION	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director, After this certific completely filled in by the funeral director,	Certification:	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) If 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	M 1 🗆	]Yes 2 □ No 28f. L	ocation (Street a City or Town, Sta	and Number or Rural Route Number, te)
_	Hospital 24 hours a Funeral I etely filled	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	, death occurred at the ti d/or investigation, in my o	ime, date and place, and o opinion, death occurred at	lue to the cause the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To the within To the compl	Me		29c. Licens	se number	29d. D	Date signed (Month, Day, Year)
	4		30. Name and address of person who completed cause of death (Item 23a) (	(Type, Print)	se number 9617 Grèneral H	as a: to	0
	Sta	te	31. Date filed (Month, Day, Year) 2. Registrar's Signature	may where	ivikine M	Sprice	
	Registr		JUL 2 2 2008 July 15. 16	parte			

			1 - State of Maryland / Department of Health and Mental Hyg	giene giene.2008 23519
	Physici /Medi			th Day Year 3. Time of Death 18 Year 6:104 M
	Examir	ner	Seasons Hospice of Northwest Hosp. Randallstown	4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 219-40-1851 6. Sex 1 Months Days Hours Min. 8. Date of Birth (Month, Day) 17 Months Days Hours Min. 8. Date of Birth (Month, Day) 18 Months Days Hours Min. 8. Date of Birth (Month, Day) 17 May 17	year) 9. Birthplace (State or Foreign Country) Maryland
	Maryland -f show lied at	tor	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ঐYes 2 □ No
	3a or 28a	al Director		log. Citizen of What Country?
36	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examinations and a marked other than the Medical Examination and the marked of the Medical Examination and the marked of the Medical Examination and the marked of the Medical Examination and the Medical	by Funeral	If Yes, Give 1 Yes 2 No Specify:	
21215-0036	vithin 72 hou ene. <b>than "natura</b> e Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Circuit Board Solderer	16b. Kind of Business/Industry Co. Zentech Manufacturing
_	0	To Be Co	to 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle,	Maiden Surname)
, Mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item Z7 is marked any injury or other traumatic enone.		19a. Informant's Name/Relationship (Type. Print)  Karl Angelo Risso (Husband)  19b. Mailing Address (Street and Number or Rural Route Number)  3808 Second St., Baltimore, M	
Baltimore,	. Pages 1 tment of H tant; If ite jury or oth		1 Burial 2 KI Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Bayview Crematory, Inc. 7/23/08	20c. Location - City or Town, State Baltimore, Maryland
g Ra	Deparril Depar Impor any in	100	21. Signature of Funeral Service Licensee Kevin E Ecker McCully-Polyniak Funeral H 237 E. Patapsco Ave., Balt	ome, P.A. o., Md. 21225-1856
1	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresponding to the cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	est, Approximate Interval Between Onset and Death
	Examiner	Jer	Sequentially list conditions	
8/60,	ficate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leadin to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to or as a consequence of:  c. Due to (or as a consequence of):	
.O. Box 68	w requires that the death certificat sbeen signed by the attending phy should be detached for use as the	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 roonths?	23d. Date of delivery Month Day Year
ecords, r	equires ma sen signed ould be del	ted by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	pacco use contribute to the cause of death? es 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
vital nec	nt ine law i ficate has b ir, page 2 sh	Completed		y prior to completion of cause of
	this of	Certification: To Be	examiner?  1   Yes 2   Aloo  1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Reside	ence 6 Other (Specify) SLATSCINS w injury occurred ITOS PICC reef and Number or Bural Route Number,
	Funeral Letely filled	Medical Ce		ause(s) and manner as stated. ate and place, and due to the cause(s)
1	within To the comple	Med	29b. Signature and title of certifier  August 29c. License number  H 4593 j	July 18 th 2018
A	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	7 0 0 0
	Stat Registra	e ir	31. Date filed (Month, Day, Year)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year G. Smith 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice - Northwest Hospice Baltimore Kandallstown 3. Date of Birth (Month, Day Year) 06 24 1931 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1**X**M 2□ F 212-28-0485 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner reast be retified at Baltimone. 1 Yes 2 □ No Completed by Funeral Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 Entaw Place USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. tem 27 is marked other than "natural", or ite other traumatic event, the Medical Extrinion 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) H&S Baker Engineer 12th arade 1echanical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roland Gilbert Smith Virginia Mason ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is eny Injury or other trau 7400 Castle Moor Road Windsor Mill MD 21244 Michelle S. Daniels/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ' 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery: 07/26/68 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Vengun C. Greene Fineral SNCS Varan Road Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician COLON CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed attending physician and for use as the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a d be detached for 1 □Yes 2 □ No 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown cate has been si , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is completely filled in by the funeral director, page 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) SEASONS 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred HOSPICE 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H45931 JULY 20 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 RETISTERSTOWN MD Deberah MAIN STREET 16rc6 31. Date filed (Month, Day, Year) Registrar's Signature State JUL 2 2 2008 Registrar

DHMH 17 Rev 1/2001

			for State Registrar		Sta	te of Ma	arylan	d / Depa <i>Cel</i>			lealth a D <i>eath</i>	ind M	lental H	-	ne <sub>No.</sub> 20	08	235	21
	Physici		1. Decedent's Name		, Last)	70.5	Cit						2. Date of I	Death	Day	Year	3. Time of Dea	ath A M
	/Medic Examin		4a. Facility Name (If	not institution	Ò	nd number)		<u></u>	4b. City	, Town, or	Location of				4c. County o	f Death	11 - 21	
	Funeral Director		5. Social Security Nu 218–22–835	ımber	6. Sex 1 M M 2	7, Aq	Edical e (In yrs. 1 80	ast birthday)	If Unde Months	er 1 Year Days	If Under 2 Hours		8. Date of 1 (Month, June	Birth Day, Ye.	ar) 1928	9. Birthpl Count	• /	oreign
	/land low		Usual Residence of 10a. State	Decedent 10b. County			10c. City	, Town or Lo	cation							111	d. Inside City L	imits
	8a-f st	Director	Maryland	Balti	more			Dunda									1 □Yes 2	No
	3a or 2	al Dir	10e. Street and Num 8254 Longs		load				10f. Zi	p Code 2122	22			10g.	Citizen of WI	hat Count	ry?	
30	in 72 hours after death with the Maryland "natural", or items 23a or 28a-f show	by Funeral	11. Maritaí Status 1 □ Never Marrie		ed 1 If Ye	Decedent led Forces? Yes 2 XI			Nas Dece f Yes, spe 1 □Yes	ecify Cuba	ispanic Orig in, Mexican, Specify:	in? (Spe Puerto I	ecify Yes or Rican, etc.)	No-	14. Race Black Specify:	, White, e		
12-0036		Completed b	(Speci	15. Decedent' ify only highes	's Education t grade compl			16a. Deced (Give life. L	kind of w	ual Occupa ork done o use retired	lurina most i	of workir	ng	16b	. Kind of Bus			
7	e filed within al Hygiene. other than " vent, ine Me		Elementary/Secon 9 years			ege (1-4or 5	)+)	Main	tain	ance	Super				anking		···	
and	ld be fil lental F ked otl ic ever	To Be	17. Father's Name (i Arthur J.								18. Mother Gertr			ile, Maic	den Surname	)		
, mary	permit, Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If Item 27 is marked other any Injury or other traumatic event, If ODE.		19a. Informant's Na Keith C. S			son		1	-						ty or Town, S ryland		Code) 222	
Jore	ages 1 ant of He		20a. Method of Disp 1X Burial 2	Cremation		from State	C	lace of Dispo	natory or	other place	י י	July			Location - C			
Баппо	ermit, Pa Departme Inportant Iny Injury		4 ☐ Donation 21. Signature of Fur		-	1	Dru	id Rid	. Name a	nd Addres	s of Facility	200 Hon	ne Of	Dung	dalk.P	.A.	aryland	
	0.07 8 00	1 188	23a. Part1. Enter th shock, or hear	e disease/o	complications	that caused	the death	4	10 5	orrer	S PO1	nt i	koad,	Dung	dalk,M	D. 2	Approximate	
,	Physician /Medical		shock, or hear Immediate Cause (I disease or condition resulting in death)	inal	a	e on each lir		6							AT FAI		Interval Betwee Onset and Dea 35 40	th
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	cuted nd ransit	Examiner	cause. Enter Under Cause (Disease or in that initiated events	lying njury	, D	ue to (or as	a conse	ience otj.										
0/00,	ate be exe hysician ai he burial-t	edical Ex	resulting in death) La	ast	d.	ue to (or as	a consequ	ence of):										
o xoo	nding puse as t	n/Med	IF FEMALE: 23b. Was decedent	pregnant		s, outcome									23d. Date	of deliver	v	
ğ	t the death by the atte ached for	Physician/M	in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	4 🗆	Live birth Pregnant a Unknown			Ectopic Other (s	pregnancy pecify)	/			-	Mon		Day Yea	r
ecords, 1	w requires that the death certificate be executed to be executed been signed by the attending physician and should be detached for use as the burial-transit	þ	Part II. Other signification	cant condition	ns contributing	to death bu	ut not resu	Ilting in the ur	nderlying	cause give	en in Part I.						e cause of deat	
בי בי	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  The Athor after death.  The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed											pe	as an Itopsy Informed	? pr	ere autopior to comeath?	sy findings ava apletion of caus 2  No	ilable e of
\ [a]	/siclan s certifi director	o Be	25. Was case referre examiner?  1 ☐ Yes 2 ☑	/	Hospital:	1 ly Innatio	not 2 🗀	ER/Outpatien	+ 2 T D	OA Othe	ar:		(Check onl		e 6 □Othe	. (0		
	*Attending Physician: The law or death. rector: After this certificate has by the funeral director, page 2 is	$\vdash$	27. Manner of Death  1 Natural  2 Accident			Date of Inju (Month, Day	ry	28b. Time of Injury		28c. Injury Work		2			njury occurre		)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin		Place of Injubuilding, etc	ury - At ho	me, farm, stre	eet, factor	y, office		2		(Street Town, St		r or Rural	Route Number	
	e Hospi	Medical	29a. Certifier (Check only one)	1 ☑ Certifying 2 ☐ Medical E	xaminer: On	To the best of the basis of manner sta	f examinat	wledge, death ion and/or in	occurre vestigatio	at the tim	ne, date and pinion, death	d place, a	and due to t ed at the tim	he caus ne, date	e(s) and mar and place, ar	nner as st nd due to	ated. the cause(s)	
	To the within To the comp	Me	29b. Signature and to	itle of certifier	_					c. License	number	-		29d.	Date signed	6	Pay, Year)	·
	T		30. Name and addre	ss of person "		ES IC		23a) (Type I		ES	001			0	7/20	108		
	Ø		PATRICK S	AFO,	4940	PASTE	RN 1	AVENUE		4LTIN	nore.	m	D 21	224	<del> </del>		<u></u>	
	Stat Registra		31. Date filed (MO)	n, Day, Mean	008	32. Begistra	ar's Signat	ure good										

DHMH 17 Rev 1/2001

			State of I State Amend #18 per FH G881 Registrar	Maryland / Depa . 7/22/08 <b>G</b>	artment of Health rtificate of Deat	n and Mental Hy Th	/gienę/ U U B Reg. No.	23522
	Dhysiai		1. Decedent's Name (First, Middle, Last)			2. Date of D Month	eath Day Year	3. Time of Death
	Physicia /Medic	_	John William Student			July	17 2008	6:20 P.M
ŀ	Examin	er	4a. Facility Name (If not institution, give street and number Broadmead	er)	4b. City, Town, or Location		4c. County of Dea	
10	-			Age (In yrs. last birthday)	Hunt Vall	ler 24 Hrs.   9 Date of B	dh O Bir	thplace (State or Foreign
14.	Funeral Director		089-09-0348 ¹¼м ²□F	91 Yrs.	Months Days Hour	s Min. (Month, D 1/21/1	ay Year) C 1917 Balt	ountry) Maryland
	D .		Usual Residence of Decedent	140.00				
	laryla shov	2	Maryland Baltimore	10c. City, Town or Lo Cockeysv				10d. fnside City Limits 1 ☐ Yes 2 ☒ No
	28a-f	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	
	death with the Maryland ma 23a or 28a-f show	O E	13801 York Road Apt. M9		21030		United St of Americ	tates
	ema 3	Funeral	11. Marital Status 12. Was Decede Armed Force	nt Ever in U.S. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mexic	Origin? (Specify Yes or N		erican Indian,
9/	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene a and Mental Hygiene is marked other than "natural", or thema 23s or 28s-f show aumstic event, the Marical Examinar must be notified at	by Fu	1 Never Married 2 Marned 1 Yes 2	₽No	1 ☐ Yes 2 <b>∑</b> No <i>Speci</i>		Specify:	white
Maryland 21215-0036	2 hour	edb	3 Ŋ Widowed 4 ☐ Divorced Year or Date  15. Decedent's Education	16a, Dece	dent's Usual Occupation		16b. Kind of Business	s/Industry
215	hin 72	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4)	(Give	kind of work done during m DO NOT use retired)	ost of working		
2	ed wit	Completed	9	Mac	hinist		Bethlehem	Steel
and E	be fill pd oth	Be	17. Father's Name (First, Middle, Last)  John William Student	Cr		ther's Name (First, Middle		
2	should be fand Mental Is marked or umatic eve	ဥ	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Num	e Hodulkaun		Zin Code)
	and 2 seath an 27 is		John William Student III		Elinor Avenu		am, Maryland	
ore,	The Head		20a. Method of Disposition	20b. Place of Dispo	esition (Name of matory or other place)	Date	20c. Location - City of	Town, State
Baltimore,	Pages ment of I ant: If its ury or o		1 ☐ Burial 2X Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	Evans Chapel-	Funeral	July 18, 2008	Forest Hil	1, Maryland
Salt	permit. Page Department Important: It any injury o		21. Signatura of Furieral Service Licensee	/ Pë	aceiul Adai tei	natives Fune	eral &Cremat	tion Ctr.,P.A
	40384		23a. Party. Enter the disease, or complications that cause		2325 York Ro		n, Maryland	
			shock, or heart failure. List only one cause on each	i line.	er the mode of dying, such	Summer A .	· · ·	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	as a consequence of):	HEAR	FAILL	IRE	
	Examiner		T. < /	HEMIC	HEART	DISEAS	SE	
	D E	lner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of):				
13	and II-trans	Examiner	that initiated events C.	as a consequence of):				
58760,	ficate be executed physician and is the burial-transit			20 2 00/100425/100 01/.				
89	- 0.3	edical	a.					
Вох	eath certif attending for use as	lan/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcor		Bectopic pregnancy		23d. Date of de	
о. П	The law requires that the death certile has been signed by the attending bage 2 should be detached for use a	Physicia		tat time of death 5	Other (specify)		Month	Day Year
<u>.</u>	that the de led by the a detached	Phy	Part II. Other significant conditions contributing to deat	n but not resulting in the u	nderlying cause given in Pa	rt 1 23e. Did	tobacco use contribute t	o the cause of death?
Vital Records,	luires tha signed id be det	d by	ATRIAL FIBRI	LLATIOI	Ú			fobabfy 4 □Unknown
000	law requir as been si 2 should i	Completed	CHRONIC KIDNE	V DISFA	SF. STAG	F 4 24a. Wa	s an 24b. Were a	utopsy findings available
		E	ANEMIA		1 110		ormed? prior to death?	completion of cause of
ıta	ysician: Th	Bec	25. Was case referred to medical examiner?		26. Pla	ace of Peath Check on		
6	Physic this co	P	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpa			ursing Home 5 Res		ecify)
חכ	ding h. After funer	tlon	27. Manner of Death  1 DNatural 5 Pending (Month, Month, 1)	njury 28b. Time of Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2		how injury occurred	
Division	er deatl	flca	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of	Injury - At home, farm, str		28f. Location	(Street and Number or F	Rural Route Number,
á	s after	Certification:	4 Homicide determined building,	etc. (Specify)		City or To	own, State)	
	To the Hospital or Attending Physician: within 24 hours alter death. To the Funeral Director: After this certified completely filled in by the funeral director; g	edical (	29a. Certifier (Check only 2 Medical Examiner: On the basis	st of my knowledge, death	h occurred at the time, date	and place, and due to the	cause(s) and manner a	s stated.
	the thin 24 the F	Medi	one) and manner  29b. Signature and title of certifier	stated.	29c. License numbe			
	¥ ¥ 5 8		BAATTAL CALL	1/1 ms	7 7 7	7300	29d. Date signed (Mon	2 M
			30. Name and address of person who completed cause of	of death (Item 23a) (Type,	Print)	0014	1/18/	0008
_	12		BARBARA CARROL	L,M.D.	13801 VC	ORK RD.	COCKE	VSVILLE. MI
	* Sta	te	31. Date filed (Month, Day, Year) 32. Regi	strar's Signature		, , , , ,		10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year MARY FRANCIS, SCHRAMM 1014 2008 8:50 pm 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HARBOR HOSPITAL BALTIMORE N/A 5. Social Security Number if Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Hours 1 □ M 2 🛛 F Months Days 93 216 28 7320 Maryland 07/18/1914 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 X No Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 720 Old Riverside Road 21225 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Counter Worker Bakery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Parks Lilly Wroten 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Robison / Daughter 251 Allwood Drive Ferndale, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 07/18/2008 Baltimore, Maryland Cedar Hill Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee many 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ally one cause on each line. Onset and Death Immediate Cause (Final STROKE disease or condition resulting in death) Due to (or as a consequence of): Exps. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or hjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4□Pregnant at time of death Day Year 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy

Physician /Medical Examiner

Department of Health ar Important: If item 27 is any Injury or other trauonce.

**Physician** 

/Medical

Examiner

10a. State

Directo

Funeral

9

Completed

Be

ဥ

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

72 hours after

filed within Hygiene.

1 and 2 should be filed wi Health and Mental Hygier Im 27 is marked other th

Pages 1

be executed

Box 687605

P.O.

Division or Vital Records,

To the Hospital or Attending Physician:

death.

this

within 24 hours after death

To the Funeral Director:
completely filled in by the f

Baltimore, Maryland 21215-0036

burial-trar physician the attending p the signed by t Id be detach cate has certificate

Examiner Physician/Medical Completed by director. Be Medical Certification: To After thi funeral

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

2 ☐ Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

1□ Yes

2 No 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

1 □ Yes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

2 ER/Outpatient 3 DOA

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

RES 000

29d. Date signed (Month, Day, Year) JULY, 16, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

5 Pending investigation

6 ☐ Could not be

determined

heriano Almeido, MO

1 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

LUCIANA 3001 ALMEIDA SHANDUER ST

BALTIMORE 21225 , MD

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

08-05515 Renee Silverman

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 23524

		I- For State Registrar	Certificate	e of Death	Re	g. No.	2002	
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last) Renee Silverman		•	2. Date of Deat Month July 18, 20	h 3. Time of		
		4a. Facility Name (if not institution, give street and 3111 Katewood Court	number)	4b. City, Town, or Location Baltimore	of Death	4c. County of Death Baltimore County		
Funeral Director		5. Social Security Number 6. Sex 1 M 2 X F	7. Age (In yrs. last birthda	y) If Under 1 Year If Under 1	s Min	h(MM/DD/YYYY) 9. Birthplace (Sta Country) 5 1960 MD	ate or Foreign	
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location		10d. Insid	le City Limits	
<b>≹</b> .#	ro	MD Baltimore	Baltin				es 2 <sub>X</sub> No	
death with the Maryland or items 23a or 28a-f sho must be notified at once	Director	10e. Street and Number 3111 Katewood Ct		10f. Zip Code 21209		Og. Citizen of What Country? USA		
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sh	Funeral	1 Never Married 2 Married Armed 1 Yes	Forces?	3. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica	n, Puerto Rican, etc.)	White, etc.		
urs after tural", aminer	ğ	3 X Widowed 4 Divorced If Yes, Give to Divorced or Dates:  15. Decedent's Education (Specify only highest g		1 Yes 2 X No specify tedent's Usual Occupation (Give		Specify: white	, 	
136 thin 72 hours te. than "naturedical Exam	Completed		(1-4 or 5+)	ing most of working life. DO NO		Manusamint Edit	ina	
2 5 5 1 5	Som	12 17. Father's Name (First, Middle, Last)	1 Fr		er's Name (First, Middle, N		Ing	
21215-0036 hould be filed within 7 and Mental Hygiene. is marked other than the weet, the Medica	Be	Donald W Collins	Lea		irley J Gr			
Baltimore, MD 21215-C permit. Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If iten 27 is mayked othe injury or other trainmatic event, the Li	ို	19a. Informant's Name/Relationship (Type, Print)  Debra L Collins/siste	4	- '	#508, Towson	nber, City or Town, State, Zip Code $n=MD-21286$	,	
ore, less 1 and of Healt If item		20a. Method of Disposition  1 Burial 2 X Cremation 3 Remova		isposition (Name of cemetery, or other place)	Date	20c. Location - City or Town, Stat		
Baltimore, permit. Pages I an Department of Hea Important: If iter		Donation 5 Other Specify: 21. It alure of Funeral Security:	Metro	Crematory 22. Name and Address of Facil	7/21/08	Catonsville, M	D	
Balti permit Departm Imports injury o	4	Bryan W Chary	<i>y</i>	Lemmon Funera 10 W Padoni	1 Home of Dua Rd Timon	nium MD 21093	nc	
Physician /Medical		23a Part I. Enter the disease, or complications that fail are. List only one cause on each line.		nter the mode of dying, such as	cardiac or respiratory arre	est, shock, or heart Approxi Betwee	mate Interval en Onset and Death	
xaminer			ined butalbit a consequence of):	al & alcohol i	ntoxication		Death	
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or a	a consequence of):					
	Examiner	cauce. Enter Underlying Cauce (Disease or injury that initiated	s a consequence of):	-				
760, icate be executed physician and the burial - transit		events resulting in death) Last Due to (or as a consequence of):  d.  X UNPENDED AMENDED 23a,27,28a-f, perME, g882 8/7/08 TT						
760, icate be ext physician the burial -	Medical	IF FEMALE: 23c. If ye		i, perME, g882	8///08 TT	23d. Date of delivery		
6876 certificat ding ph		23b. Was decedent pregnant in the past 12 months?	s, outcome of pregnancy	Fetal death 3 Ector	oic pregnancy	Month Day	Year	
Box 687 e death certification attending ed for use as t	Physician	1 Vos 2 v No 0 Hotour	gnant at time of death 5	Other (Specify)				
ires that the displayed by the	by PI	Part II. Other significant conditions contributing	to death but not resulting in	the underlying cause given in F		obacco use contribute to the cause  2 No 3 Probably 4		
ords,   w requires s been sig	eted			·		an 24b. Were autopsy findi	ings available	
of Vital Records, ng Physician: The law require this certificate has been simeral director, page 2 should b	Completed		<del>_</del>		autop perfo	rmed? death?	2 No	
Vital Rec ysician: The I his certificate I	Bec	25. Was case referred to medical examiner?		Other:	h (Check only one)		lan-seri	
n of Viding Physical  After this funeral dir	٩	1 Yes 2 No 27. Manner of Death 28a. Da	te of Injury 28b. Tim	atient 3 DOA OTHE 4 DOA 1 DOA	Nursing Home 5 28d. Describe	Residence 6 Other: Scene		
ion (tending leath.	ation	Natural 5 Pending L	nth, Day,Year) /08 FND unk	1 Yes 2 🕽	No UNK			
Division tall or Attending and after death.	ertification:	3 Suicide 6 X Could not be 28e. Pl	ace of Injury - At home, farm  y) Home	, street, factory, office building,	etc. 28f. Location (Sor Town, Sor Baltimo	Street and Number or Rural Route state) 3111 Katewood re, MD	Number, City	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - mansil - ma	Medical C	29a. Certifier 1 Certifying Physician: To the body one) Medical Examiner: On the bas	est of my knowledge, death s of examination and/or inve	occurred at the time, date and pastigation, in my opinion, death of	place, and due to the caus	e(s) and manner as stated.		
To witi	Me	and manne	r stated.	29c. License numbe	r	29d. Date signed (Month, Day, Y	'ear)	
7		antifell	)	O.C.M.E.		July 19, 2008	<del></del>	
1		30. Name and address of person who completed ca Laron Locke MD. Assistant Medi	,	Penn Street, Baltimore, I	MD 21201			
St: Regist		31. Date filed (Month, Day, Year) 2008 32	egistrar's Signati	parke				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23525 Certificate of Death Reg. No. 1. Decedent's Name (First, Midele, Last) 2. Date of Death Swecker 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Future Care Homewood Baltimore N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) May 12, 1934 Birthplace (State or Foreign Country) Days Hours Min 1 □ M 2 X F 74 234-52-8515 West Virginia Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits Maryland N/A MXYes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3939 Roland Avenue 21211 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Yes 2 No White Specify: 3 ☐ Widowed ♣ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Senior Elementary/Secondary (0-12) College (1-4or 5+) 12 Apartment Building Receptionist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Everett Gay Alta K. Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Ruby Friend 3838 Roland Avenue, Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/21/2008 Catonsville, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licensee Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23b. Was decedent pregnapt 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy in the past 12 mont Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 □ Other: Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred tural 5 Pending 2 Accident investigation 1 Yes 2 No

**Physician** /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-translt Division of Vital Records, P.O. Box 68760,

**Physician** /Medical

Examiner

**Funeral** 

Director

28a-f show

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Itema 23a

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7 is marked other than "natur traumatic event, the Medical.

permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once.

Examiner must be notified at

Directo

Funeral

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Completed

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with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Medical Certification; To

Physician/Medical Examine Be Completed by

signed by the aid be detached f as been signal page this certificete After this certific funeral director. after death.

Director: All
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within 24 hours : To the Funeral I completely

6 Could not be determined 4 - Homicide 29a. Certifier (Check only one) 30. Name and address of person

3 ☐ Suicide

State Registrar

29b. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 20 2008 **Physician** Erma Smith 6:40 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Villa Nursing Center Baltimore County Catonsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2 XF Oct 8, 217-16-8787 84 1923 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. The marked other than "natural", or Items 23a or 28a-f show ant; If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medica Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits N/A Baltimore Maryland 1√ Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 1234 Patapsco St., Apt. 8 21230 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Completed by Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bindery Dept. Printing Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Ferdinand Smith Theresa V. Harvey P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Burck (Niece) 719 Obrecht Rd., Sykesville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 7/24/08 Baltimore, Maryland 4 ☐ Donation 5, ☐ Other (Specify) 21. Signature of Frieral Service Licensee Kevin E Ecker Name and Address of Facility
McCully-Polyniak Funeral Home,
130 E. Fort Ave., Balto., Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month 5 Other (specify) led by the a 9 Unkno Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Lunknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes □ No 24a. Was an this certificate has autopsy page or Attending Physician: within 24 hours after death.

Fo the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Deat 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Hospital riffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

2 2 2008

SIGN Polh

36 Name and address of person who completed cause of death (Item 23a) (Type, Print)

procendo 2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 10:20 AM LUDMILA SHAFIR July 18 2003 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Baltimere Sinai Haspital 40 9. Birthplace (State or Foreign Country) UKRAINE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 X F 216-25-7407 72 10/16/1935 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is anarked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Be Completed by Funeral Director MD N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3601 FORDS LANE, #305 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No WHITE Specify Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) BOOKKEEPER CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) YABLOCHNIK NUHIM ELKUN ZINA 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 FOX CREEK COURT, OWINGS MILLS, MD ANNA FRIEDMAN / DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 07/20/2008 REISTERSTOWN, MD 21. Signature of Funeral Service Lices 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a.1 art1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on earn line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to or as a consequence of): /Medical Examiner theres derote vascular derease if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed aheles Mellitu and burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed2 1☐ Yes 2☐No 2□ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ■ER/Outpatient 3 DOA 1 🔲 Inpatient Medical Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Huser...
within 24 hours after deau...
To the Funeral Director; Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D53377 I M . D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAHASARIW S. ALI, M.S. 2401 West Re 2401 West Belvedere tre, Baltimore, MD 21215

Registrar DHMH 17 Rev 1/2001

State

Judmile,

Maryland

Baltimore,

Division or Vital Records, P.O. Box 68760,

M.D.

2. Registrar's Signature

31. Date filed (Month, Day, Year)

JUL 22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) SILVER **Physician** MARI) /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOWARD HOWARD COUNTY GENERAL HOSPITAL COLUMBIA Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number Days 02/26/1943 142-34-0953 NJUsual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 □Yes 2 No Director HOWARD COLUMBIA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21045 8630 VAST ROSE DRIVE Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married WHITE 1 ☐ Yes 2 🛣 No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) NAVAL INTELLIGENCE PROJECT MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle, Last) Be P SILVER **EDITH** KURZER MARTIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8630 VAST ROSE DRIVE, COLUMBIA, MD 21045 BARBARA SILVER / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 ☐Removal from State COLUMBÍA MEMORIAL PARK 07/20/2008 COLUMBIA, MD 4 Donation 5 ☐ Other (Specify 22. Name and Address of Facility SOL LEVINSON & BROS., INC. of Funeral Servic Licent 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 blications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, or conshock, or heart failure. List only hic Lateral Schools Immediate Cause (Final 1ears disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perforn 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural

Physician /Medical Examiner

Department of F Important: If ite any Injury or oth

**Funeral** 

Director

28a-f show

death with

Pages 1 and 2 should be filed within 72 hours after

Health and Mental Hygiene. em 27 is marked other than

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f st other traumatic event, the Medical Examiner must be notified

the burial-trans physician attending ph been signed by the should be detached certificate has I rector, page 2 s funeral Certification: After

Division or Vital Records, P.O. Box 68760,

or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director:

State Registrar

Medical

28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only 29c. License number 29b. Signature and title of certifier

053987

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENNETH 300 ARMORY Pf, SV, TE 3G BALTIMORY Registrar's Signature

Day, Year) 31. Date filed (Month

2 Accident

3 Suicide

4 Homicide

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	C	Certificate of		Re	<sub>eg. No.</sub> 2008	23529
	Physici	an	1. Decedent's Name (First, Middle, Last)		CINCED		Date of Death     Month	h Day Year	3. Time of Death
	/Medic Examin		SAMUEL  4a. Facility Name (If not institution, give street and numb	er)	SINGER 4b. City, Town, o	r Location of Death	JULY	19 2008 4c. County of Deat	7.43A
-			RUXTON OF PIKESVILLE HE		PIKESVI			BALTIMOR	E
	Funeral Director		5. Social Security Number 216-01-5287	Age (In yrs. last birthd	Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 01/26/	9. Birt Co	hplace (State or Foreign untry) MD
Maryland 21215-0036 td 2 should be filed within 72 hours after death with the Maryland tith and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the M-deal Ever in a crust be notified as		10a. State 10b. County	10c. City, Town or	r Location				10d. Inside City Limits	
	ne Mar 8a-fsl	Director	MD BALTIMORE	PIKESV					1 □Yes 2 No
	ath with the 23a or 2	ral Dìre	7 SUDBROOK LANE			1208			USA
	nours after de aral", or items Levania erra	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decede Armed Force I □ Yes 2 □ If Yes, Give Year or Date	S? ŽiNo	13. Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🛣 No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
215-	in 72 h e. in "natu w dien	Completed	15. Decedent's Education (Specify only highest grade completed)	(G	ecedent's Usual Occup Rive kind of work done of fe. DO NOT use retired	oation during most of work d)	ing	16b. Kind of Business/	ndustry
212 212 ed with ygjene. jer thai	ed with ygiene yer tha t, th	Com	Elementary/Secondary (0-12) College (1-40	r 5+)	MER	CHANT		HARDWAR	E STORE
and	eve d stal	To Be	17. Father's Name (First, Middle, Last)  JACOB	SINGE	R	18. Mother's Name	e (First, Middle, N		ZEROF
ary	shoul and M is mar aumati	F	19a. Informant's Name/Relationship (Type. Print)	19b. M	lailing Address (Street	and Number or Rur		City or Town, State, 2	
e, S	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		ELLIOTT SINGER/ SON  20a. Method of Disposition		7 SWANHILL			, MD 2120 20c. Location - City or	
Baltimore,	permit. Pages Department of Important: If its any Injury or o		1 ♥ Burial 2 □ Cremation 3 □ Removal from Sta 4 □ Donation 5 □ Other (Specify)	te cemeters ATTZ	sposition (Name of CHAIM CON(		1/2008	BALTIMORE,	MD
Ba	Depar Impor any Ir	l, i	21. Signature on Funeral Service Licensee		22. Name and Addre			SON & BROS PIKESVILLE	
Physician /Medical Examiner	g 15	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Immediate Cause (Final disease or condition).							
		resulting in death)  Due to (or	as a consequence of):		7			2 0	
Ļ	je je	Ē	Sequentially list conditions.	Menta- as a consequence oi):	tina S	stage			5 ym
/		camìr	that initiated events						
68/60,			Due to (or	as a consequence of):				:	
89	ing phy	Medical	IF FEMALE:						
hat the death ce ad by the attendidetached for use	Physician/I	23b. Was decedent pregnant in the past 12 months?	h 2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of del Month	ivery Day Year	
	n signed by	ρ	Part in Other significant conditions continuoung to death but not resulting in the underlying cause given in Part i.						
e .	as bee	Completed	24a. Was an autopsy 24b.					topsy findings available completion of cause of	
ב ה	ficate h						perforn	ged? death?	2 🗆 No
VII	ysicial is certii directo	o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpo	atient 2 ☐ ER/Outpa	atient 3 DOA Oth	er; 4 Nursing Ho		e) nce 6 □Other (Spe	cifu)
SION OT	th. : After thi	tion: To	27. Manner of Death  115 Natural  28a. Date of 1  (Month, 1)  2 Accident investigation		e of 28c. Injur			w injury occurred	ліу) -
DIVIS	after des I Director	Certification:	3 Suicide 6 Could not be 28e, Place of	Injury - At home, farm, etc. (Specify)	street, factory, office		28f. Location (St. City or Town	reet and Number or Ru , State)	ıral Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		Medical C	29a. Certifier (Check only one) Certifying Physician: To the best and manner	s of examination and/o	eath occurred at the tile or investigation, in my o	me, date and place, ppinion, death occur	and due to the cared at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
- 5	To the	Ĭ	29b. Signature and fitte of certifier		29c. Licens		29	od. Date signed (Monti	
	3	-	30. Name and address of person who completed cause of	of death (Item 22c) (To	ne Print)	1731		7 19/0	8
			RGAN-CARDEN, MO (656	5 N. Cha	ule St. 176	buson, N	1D 212	204	
	Star Registra		31. Date filed (Month, Day, Year) 3. Regi	strar's Signature	sele				

		1- State of Maryland / Department 23aPtII, 25 per me 2881.0	of Health and Mental Hygieng 008 23530
	ician		2. Date of Death  Month Day Year 7:/0AM
		4a. Facility Name (If not institution, give street and number)  4b. City, To  COMOC CUT CV  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  Months  Months	Town, or Location of Death 4c., County of Death Was wing tour
th the Maryland or 288-f show	Irector	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  10c. Sireet and Number  10f. Zip Co	10d. Inside City Limits 1 Dres 2 No Code 10g, Citizen of What Country?
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Examinat must be notified at	by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	ant of Hispanic Origin? (Specify Yes or No- fy Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036 of 2 should be filed within 72 hours aft th and Mental Hygiene. 27 is marked other then "natural", or traumatic event. 12, 12, 14, 15, 17, 17, 17, 17, 17, 17, 17, 17, 17, 17	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  None	done during most of working retired) N/A
aryland 212 2 should be filed with and Mental Hygiene is marked other than	To Be	Eugene Thompson	18. Mother's Name (First, Middle, Maiden Sumame)  Ruby Duncan
ore, Ma les 1 and 2 of Health a of Health a of Health a		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (S  1275 Plank  20a. Method of Disposition  1 □ Rurial 2 □ Cremation 3 □ Removal from State	of Date 20c Location - City or Town State
Baltimore, permit. Pages 1 as Department of Hea Important: If item any injury or othe	OUCE.	Jerome granerouch 4001 Ri	Address of Facility Gonce Funeral Service, P.A. itchie Highway Baltimore, Maryland 21225
Water be executed water be executed with the burial-transit the burial-transit	ı	23a. Aart1. Enter the disease, of complications that caused lhe death. Do not enter the mode of shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in dealh)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onesit and Death Sweeks  Stihal bleed with  Sweeks  Tion of blood  CERTIFICATION  CERTIFICAT
ords, P.O. Box 6( requires that the death certific een signed by the attending p nould be detached for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specific pregnancy)	gnancy 23d. Date of delivery
Rec ne taw nhas b ge 2 st	Completed by Ph	Place of the significant continuous continuous to death but not resulting in the underlying caus	23e. Did tobacco use co ute to the cause of death?  1 Yes 2 0 3 Probably 4 Unknown  24a. Was an autopsy findings available prior to completion of cause of death?
on of Vital ling Physician: T. After this certificate funeral director, pa	To Be	25. Was case referred to medical examiner?  127 Yes 25. Was case referred to medical examiner?  128 Yes 25. Was case referred to medical examiner?  1 Logital: 1 Inpatient 2 ER/Outpatient 3 DOA  27. Mann Death 28a. Date of Injury (Month, Day Year)  1 Logital: 28b. Time of Injury (Month, Day Year)	26. Place of Death (Check only one)
Division tal or Attending s after death. al Director: After	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)	
Divisic  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the it	Medical	and manner stated.	n my opinion, death occurred at the time, date and place, and due to the cause(s)
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	_	29c. Signature and title of certifier  29c. Light Standard Control of Control	icense number 0435 g 29d. Date signed (Month, Day, Year)
s	tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	It. Hagerstown Md 21742
Regis	trar	JUL 2 1 2008 tomer to books	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NELVIN 2003 1126A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner - Rollina Koad Baltin Manor atonsville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 04 20 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Funeral Months Days Hours 219.10.7076 1 M 2 □ F MD Director Usual Residence of Decedent 10a. State 10b. County 10d Inside City Limits 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiliar must be notified at Baltimore MD Director 1 ☐ Yes 2 No GWYNN Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5706 21207 Prince USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 M No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Þ 1 ☐ Yes 2 XNo Specify. Black Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is marked other than General Motors Worker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any highry or other traumatic event, ODGs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21267 Georges Street Gwynn Oak, MD Tille 20c. Location - City of Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Dudon ughn C. Granc Funoral SNO 21. Signatur of Funeral Service License Randalistown MD 21133 iberty Road Approximate Interval Between Onset and Death 23a. Part 1. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart-failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ISCHEMIC **Physician** ARDIOMYOPATH /Medical Examiner ORUNARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-trans The law requires that the death certificate be execu Due to (or as a consequence of): Physician/Medical the attending p for use as t IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 □ Yes 2 □ No. 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 HEIMER'S 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate 1 □ Yes 2 No or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this Medical Certification: To To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 24 hours a 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I and manner stated. 29b. Signature and title of certifier

8

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

State Registrar 31. Date filed (Month, Day, Year)

mA

210 Business 92. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

CENTER DAVE

DU059

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 19:15 PM TAYLOR 2008 RASHARD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Jun 15, 1982 Maryland 26 Director 213-06-6917 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location show ral", or Items 23a or 28a-f sho Examiner must be notified at 1 ☐ Xes 2 ☐ No Director **Baltimore City Baltimore** Maryland 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number U.S.A 21229 4728 Williston Street Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Yes 2 No 1 ⊟ Yes 2 ⊟ Nye Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: Specify: Black δ 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) College is marked other than and Mental Hygiene. Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) traumatic event, Be Theresa Boyd Steven Taylor ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4728 Williston Street Baltimore, Maryland 21229 of Health Theresa Boyd Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Pages 1 1 Durial 2 Cremation 3 Removal from State Department of Important: if it any injury or conce. Baltimore, Maryland 07/23/08 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 22. Name and Address of Facility 21. Signature of Funeral Service Lige Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 de ellerande 23a Tart 1. E.p. r the diseas or complications that clused the disease or shock wheat failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to for as a condition Approximate Interval Between Onset and Death not enter the mode of dving, such as cardiac or respiratory arrest Physician FAILURE /Medical Examiner CHEMOTHERAPY TOXICI T Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and d for use as the burial-transit ANE MIA APLASTIC Due to (or as a consequence of): Physician/Medical detached for use as 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal death 3 🗌 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> funeral director, page 2 should be 3 Probably 4 Unknown Be Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 2 No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this ce completely filled in by the funeral dire 1 Umpatient 2 ER/Outpatient 3 🗆 DOA 1 Yes မ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manne Death 28c. Injury at Work? Certification: 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers

Registrar DHMH 17 Rev 1/2001

State

VARGA

31. Date filed (Month, Day, Year) JUL 2 2 2008

Zose

32. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene To State Amend 31 perDVR g881 //22/08 To Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 11:00 A. Ricky P. Trivett 2008 July 16 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Jessup 7853 Sellner Road Lot 13 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F 52 Maryland 03/14/1956 **Director** 220 66 0081 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Anne Arundel Jessup Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7853 Sellner Road 20794 U.S.A. Lot 13 Pages 1 and 2 should be filed within 72 hours after death Funera Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No f Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Hote1 10th Ith and Mental Hygier 27 is marked other the traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Edwin Trivett Gladys Dowler P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health and Important: If item 27 is m any injury or other traum Gladys McNeir / Mother 7853 Sellner Road Lot 13 Jessup, Maryland 20794 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 07/16/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Part1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, from the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): physician the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of prior to completion death?
1 ☐ Yes 2 ☑ No autopsy perform 1□ Yes 2 📭 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 1 D Natural Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours af le Funeral D letely filled i 1 Descritifying Physician: To the best of my knowledge-death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or revestigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner stated. Medical 29a/Certifier completely exvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 546 FILL (0B)
Easten Are Beltemin 21224 29d. Date signed (Month, Day, Year) Signature and title of

Registrar DHMH 17 Rev 1/2001

State

31. Date filed

pleted eause of death (item 23a) (Type

's Signature

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Registra

Year,

(Month, Day

cott Thomas	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar  Certificate of Death  Reg. No. 2008 2353						
Physician/	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death						
ledical Examiner	Scott Freston Monas						
Ala.	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital  Baltimore						
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign						
Director	217-58-5308   1XM 2 F   50   Yrs.   Months Days Hours Min.   04-07-1958   Maryland						
	Usual Residence of Decedent						
w any	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  MD Baltimore 1 Yes 2 X No						
Aaryland 28a-f show 1 at once. ector	The state of the s						
the Maryland or 28a-f sh iffied at one	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 U.S.A.						
s 23a e notil	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,						
or items 23 must be no	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.						
ral", o	3 Widowed 4 X Divorced of Specify: 1 Yes 2 No specify: Specify: White						
hours at 'natural Examin	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry						
5-0036 ed within 72 hour lygiene. other than "natt he Medical Exan Completed	Elementary/Secondary (0-12)   College (1-4 or 5+)   Logistics Engineer   Defense						
5-0036 lied within 7 Hygiene. I other than the Medica	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)						
215 be file ntal H rked o ent, ti							
ID 21215-003 should be filed withi and Mental Hygiene. 77 is marked other th natic event, the Med To Be Comp	David Dutrow Thomas III   Nadine Dunnigan						
ore, MD 21215-0036 St. 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f she her traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Nadine Inomas / Mother 2515 Boston Street, Baltimore City, MD 21224  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State						
Baltimore, MD 21215-0036 bermit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If iten 27 is marked other than injury or other traumatic event, the Medical To Be Comple	1 Burial 2 X Cremation 3 Removal from State crematory or other place)						
Itim it. Pag rtment rtant:	4 Donation 5 Other Specify: Hilltop Service Corp. 07/19/2008 Towson Maryland 21. Sympture of Fineral Service Licenses 22. Name and Address of Facility						
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum:	Ruck lowson Funeral Home, Inc						
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart.  Approximate Interval						
/Medical Examiner	failure. List only one cause on each line.  Immediate Cause (Final disease a Head injury  Between Onset and Death  Death						
Aammer	or condition resulting in death)  Due to (or as a consequence of):						
p	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):						
nsit Examiner	cause Enter Underlying Cause (Disease or injury that initiated						
Exa Exa	events resulting in death) Last Due to (or as a consequence of):						
Division of Vital Records, P.O. Box 68760,  Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and rely filled in by the funeral director, page 2 should be detached for use as the burial - transit al Certification: To Be Completed by Physician/Medical Ex	X UNPENDED AMENDED 23a,27,28a-f, perME, g882 8/8/08 TT						
760 icate b g physi the bu	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 4 Using high						
ox 6876(eath certificate eath certificate attending phy for use as the trians/mersician/Mersicia	past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year  4 Pregnant at time of death 5 Other (Specify)						
J. Boy truction death by the attracted for ached for Physi	1 Yes 2 No 9 Unknown 9 Unknown						
P.O. s that the med by detach	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown						
duires t en sign ald be c							
Records, The law require ficate has been sig ; page 2 should bb Completed	autopsy prior to completion of cause of performed?						
tal Rectinan: The lectificate I	1 ✓ Yes 2 No 1 ✓ Yes 2 No						
irector	25. Was case referred to medical examiner? 26. Place of Death (Check only one)  examiner? 1 ✓ Norsing Home 5 Residence 6 Other:						
of Ving Physican After this Tuneral different on To	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  28d. Describe how injury occurred						
ion tendin sath. or: A	Natural 5 Pending 2 XAccident Investigation 7/14/08 approx. 1X Yes 2 No fall						
Division of ital or Attending Lars after deading Lars and Directors After and Directors where the function by the functivities of the function	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of Rural Route Number, City or Town, State)						
Divi	4 Homicide determined (Specify) Commercial/ Trade facility 7323 Aviation Blvd.						
Modical Examinar On the basic of examination and/or investigation in my entring doubt accurred at the time, date and place, and due to the							
To the within 7 To the complete	and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)						
16.	Corne Haller O.C.M.E. July 18, 2008						
6,7	30. Name and address of person who completed cause of death (Item 23a)						
Oto,	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
State Registrar							

DHMH 17 Rev 1/2001 OCME 2006

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 1955 PM Deborah leres JUL 17 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 1 M 2 X 1-2-1955 MD 215-64-8943 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Dundalk MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 746 Aldworth Road USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Data Entry Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James O. Bull <u>Virginia L. Brooke</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Teresi - Husband 746 Aldworth Rd, Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Harford, MD 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial 7-22-08 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licensee 9th let PA, 2134 Willow Spring Rd, 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 7 DAYS ENCEPHALOPATHY HEPATIC Due to (or as a consequence of): ZHTNOM LIVER CIRRHOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ANo Year Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performed? yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical **Examiner** 

law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r 28a-f show notified at

"natural", or items 23a or edical Examiner must be

with the

death v

filed within 72 hours after

is marked o

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau

Baltimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be

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Physician/Medical à Completed director, Be

attending physician for use as the buria Certification: To this To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After

State Registrar

Medical

IF FEMALE: 23b. Was decedent pregnant

1 Yes 2 No

5 Pending investigation

6 Could not be determined

27. Manner of Death

1 🔀 Natural

2 Accident

3☐ Suicide

29b. Signature and

29a, Certifier

4 Homicide

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

JULY 17, 2008

The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The course of the cause (s) and manner as stated. and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

D65038

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEDICAL DOCIOR

VISHNUPRIYA, ND 4940 EASTERN AVENUE BALTIMORE MID 21224

31. Date filed (Month, Day, Year)

3 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, 23536 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2008 **Physician** 20, July 11:15 PM Phyllis M. Taylor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Apt. 3522 8820 Walther Blvd. Baltimore Parkville Hours Min.

8. Date of Birth (Month, Day, Year)

May 31, 1917

9. Birthplace (State or Country)

May 31, 1917

Michigan 5. Social Security Number If Under 1 Year 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 M XXF Director 215-10-9022 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hygiana. 10a. State 10c. City, Town or Location 10b County 10d. Inside City Limits 7 is marked other than "neturel", or items 23a or 28e-f ahow treumatic event, the Medical Exeminer crust by raffiged at 1 ☐ Yes XX No Director MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 8820 Walther Blvd. Apt. 3522 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ★ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No Specify: Baltimore, Maryland 21215-0020 Specify: White Completed by XX Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillian Lewin ပ Walther Ernest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1616 Willemore, Springfield, Il. 62704 of Health of Item 27 Is Harriet Steahly /Daughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If It eny Injury or conce. X1X Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Memorial Grdn. 7/22/08 Finksburg, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FecilityEckhardt Funeral Chapel P.A. 21. Signature of Fineral Service Licensu 11605 Reistesrtown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner attending physician and for use as the bunal-transit The law raquiras that the death certificate ba axecuted Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 □ Probably 4 □ Unknown fibrillation 2 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes en autopsy performed? this cartificate has ral diractor, page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No funeral diractor. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? or Attending 5 Pending investigation 1 Natural daath. 1 ☐ Yes 2 ☐ No I Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e To the Funeral C completaly filled 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dev. Year) monias D58646 JU/4 21 2000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Boulevard Parlev. 16, U41) 21234 Anna Monias 8800 Walther

State Registrar 31. Date filed (Month, Day, Year)

32. Pagistrar's Signature

Sien H Sperti

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death Day Month Year Physician Crystal Jean Turnbaugh 2008 July 2:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours 218-88-7375 Months Days 1 □ M 2/2] ₹ 45 July 3, 1963 Maryland Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Baltimore Maryland 1 ∏Xes 2 ☐ No Baltimore Director 10g. Citizen of What Country? United States Of America 10e. Street and Number 10f. Zip Code 3047 Huntingdon Avenue 21211 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2 ☒ No Specify: ģ Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unemployed unemployed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Wayne Turnbaugh Betty Lou Carter ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa L. Buchanan/ niece 2616 Hampten Avenue Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel—Bel Air 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Forest Hill, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lars Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disass or njury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Examiner Itean bakes Records, P.O. Box Division of Vital

burial-trar attending physician for use as the buria ned by the a cate has been signed by page 2 should be detach To the Hospital or Attending Physiclan: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director,

**Funeral** 

Director

show

the

with

death v

Pages 1 and 2 should be filed within 72 hours after

permit. Pages 1 and 2 to Department of Health an Important; If Item 27 Is any injury or other traus

**Physician** /Medical

Maryland 21215-0036

Baltimore,

th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, I'm Medical Even her count by northly at

2

31. Date filed (Month, Day, Year) State Registrar

(Check only one)

29b. Signature and title of certifier

and manner stated.

29c. License number

TIMERE ILLD

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

828EUTAG HOREWITZ 32. Registrar's Signature

Registra

William.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 23a State of Maryland / Department of Health and Mental Hygiene 15,27,28a-f per me. 2881,07621/08dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23 Year **Physician** brothy Whalen D50PM 08 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Sandy Spring, MD Brooke Grove RNC Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 F Months Days 103 20 6167 82 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location "naturel", or Iteme 23a or 28a-f ehow idical Examinar must be notified at 10d. Inside City Limits Director 1X Yes 2 No Florida Indian River Vero Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 826 24th Avenue 32960 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: δ Specify. 3 XWidowed 4 ☐ Divorced White th and Mental Hygiene.
If is marked other than "natur treumatic event, the Mudical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care ould be filed w 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Karl Jurgensen Marie Hausor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Daniel Whalen 425 Scooter Point (son) Geneva, Florida 32732 permit. Pages 1 and Depertment of Healt important: If Item 27 eny injury or other 1 Baltimore. 20b. Place of Disposition (Name of cometery, crematory or other place)
Hillcrest Memorial
Gardens 20a Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 6-27-2008 4 □Donation 5 ☐ Other (Specify) Ft. Pierce, FL eral Service Lice Fleck Funeral Home, Inc. 7601 Sandy Spring koad Laurel, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner HEMATOMBO PROPROPROPRIO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of The law requires that the death certificate be executed UBDURAC Due to (or as a consequence of) 68760 use as Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day 5 Other (specify) signed by the e Ö 9☐ Unknown 9 Unknown مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificete has autopsy performed? page 1 ☐ Yes 2 DNO 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 XYes 2 1 Other: 4 Preursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 Pending investigation 4-II-Hatural efter death. Unknown 2 Accident **Unknown**<sup>M</sup> 1 ☐ Yes 2X No Multiple falls the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Unknown To the Hospital within 24 hours e Unknown 1 Contriving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0057630 06-25-2008. Um. H.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **DVENUE** SILVER SPRING, MD GEORGIA , STG 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 2 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05487 State of Maryland / Department of Health and Mental Hygiene Thomas William Weber Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 17, 2008 0948 hrs **Medical Examiner** Thomas William Weber Thomas William Weber, Jr. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Howard Howard County General Hospital Columbia If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Country) Months Davs Hours Min Director 10/02/1956 NJ Yrs 198 46 9468 1X M 2 F 51 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 XNo Columbia MD Howard permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21.046 9628 Green Moon Path Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Married Yes 2 X No Yes, Give Yea Yes 2X No specify: Specify: White 3 Widowed 4 Divorced \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+ the Medical NASA Computer Engineer 5+ 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) nt: If item 27 is marked other traumatic event, Virginia Horner Be Thomas W. Weber, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ M M 9628 Green Moon Path Columbia, MD 21046 Jo C. Weber/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition ltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Ardent Crematory 7-23-2008 Hanover, MD Important: Donation 5 Other Specify 9 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21 Signature of Funeral Service Licensee M01044 MD 21043 4112 Old Columbia Pike Ellicott City, 0 Approximate Interval 23a. Part I. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Lymphocytic Myocarditis Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed #1 per Me g881 7.22.08 TT 23a,PII,27,perME, g882 8/11/08 TT Physician/Medical X AMENDED X UNPENDED the attending physician and for use as the burial -Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Yes 2 No 3 Probably 4 ✔ Unknown ģ ۵. Biventricular hypertrophy & four-chambers dilatation Completed Records, 24a. Was an 24b. Were autopsy findings available peen prior to completion of cause of autopsy death? has performed' 2 No ✓ Yes 2 1 V Yes certificate 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical of Vital Be examiner? Hospital: 1 Other<sub>4</sub> Nursing Home 5 Other Inpatient 2 ER/Outpatient 3 DOA Residence 6 After this 1 ✔ Yes မ No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27 Manner of Death 1 X Natural Yes 2 No Division Pending Director: Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) filled To the Hospital o within 24 hours af To the Funeral D (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 18, 2008 O.C.M.E. 11 a

OCME

111 Penn Street, Baltimore, MD 21201

State

Registra

11

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed rause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

CARLES

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Betty J Woodall July 9:05a<sup>M</sup> 18. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 305 College Futurecare Chesapeake Arnold Anne Arundel Parkway 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 214-20-3996 1 □ M 2 🖾 F 11/29/1926 **Director** 81 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examination in other traumatic event, it a Medical Examination in other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 ☐ XNo MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2667 Carrollton Road 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Ď 1 ☐ Yes 2X ☐ No Specify. White 3 ☑ Widowed 4 ☐ Divorced Specify: Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beautician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lloyd Lilly, Sr. ပ Dorothy Layner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Woodall/son 2667 Carrollton Rd., Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Removal from State Meadowridge Cemetery 7/23/2008 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home., PA 3111 Mountain Rd. Pasadena 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ST months /Medical resulting in death) Due to ( // as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence on The law requires that the death certificate be executed the burial-tran and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy in the past 12 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Wiknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 ŪNo 2 □ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes Hospital: 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manne Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation death. 2 ☐ Accident 1 ☐ Yes 2 ☐ No after death the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide To the Hospital within 24 hours a rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check onl) one) and manner stated. 29b. Sign 29c. License number 29d. Date signed (Month, Day, Year) Name and address of reson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar			
DHMH 17 Rev 1/2001			

			Please Type or Prin				•	_	<b>)</b> .
			1 - State Of IVIS	*	artment of t rtificate of	Health and Me <i>Death</i>	ntai Hyg	er No 200	8 23542
			Decedent's Name (First, Middle, Last)			2.	. Date of Deat	h	3. Time of Death
	Physicia /Medic		Paul E. Walters				July (	15 <sup>ay</sup> 2008	3 11:30A M
	Examin	er	4a. Facility Name (If not institution, give street and number) Stella Maris Hospice			or Location of Death		4c. County of D	
-6	Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year		. Date of Birth		Birthplace (State or Foreign
	Director		401-32-9040	7 Yrs.	Months Days	Hours Min.	Date of Birth Month, Day, 9-12-	1930	KY KY
	/land iow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Mar	ctor	MD Baltimore	Dundalk					1 TyYes 2 □ No
	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show diest Everiner must be notified at	Completed by Funeral Director	10e. Street and Number 7405 Kirtley Road		10f. Zip Code 21 222			0g. Citizen of What USA	Country?
	ms 23	neral	11 Marital Status 12. Was Decedent	Ever in U.S. 13.		Hispanic Origin? (Specif an, Mexican, Puerto Ric		14. Race - A	American Indian,
36	or ite	y Fui	Armed Forces?  1 □ Never Married 2 □ Married 1 □ ¥es 2 □ If Yes, Give	No.	If Yes, specify Cub 1 □ Yes 2 ANo	an, Mexican, Puerto Ric Specify:	can, etc.)		/hite, etc. Vhite
21215-0036	hours	ed ba	3 Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education	Rozea	dent's Usual Occu	pation		16b. Kind of Busine	
215	thin 72 e. an "ne Madik	nplet	(Specify only highest grade completed)  Elemantary/Secondary (0-12)  College (1-4or 5	(Give	kind of work done DO NOT use retire	during most of working d)	1/17		,
121	led wil Hygien her th	Con	12	<u> </u>	Machine	Operator			nufacturing
and	d be fi ental F ked ot c evel	To Be	17. Father's Name (First, Middle, Last)  Jackson Walters			18. Mother's Name (F			
Maryland	and M s mar	F	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	l and Number or Rural F			te, Zip Code)
, S	and 2 lealth m 27 i		Nicole Lyons - Daughte	<del>,                                      </del>		ey Road,			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Pacifical Eventuals and injury of other traumatic event, the Pacifical Eventuals and once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State		nsition (Name of matory or other pla Hill Cei			20c. Location - City M:オオーム	River, MD
alti	mit. Poartme		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee						neral Home
<u>~</u>	and Per	3	· Carrier			4 Willow	-		
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not ent ne.	ter the mode of dyi	ng, such as cardiac or r	respiratory arre	est,	Approximate Interval Between Onset and Death
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	Examiner								
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<b>Ö</b> .	execu an and ial-trai	Exar	Cause (Disease or injury that initiated events resulting in death) Last	a consequence of):					
876	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	lical	d						
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Ğ.	death	iciar		2 Fetal death 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	су		Month	Day Year
P. O.	d by the deletached	Phys	9 ☐ Unknown 9 ☐ Unknown  Part II. Other significant conditions contributing to death bit	ut not reculting in the u	ndadujna sauca si	on in Bort I	220 Did tob	acco use contribut	e to the cause of death?
Records,	uires than signed Id be det	d by	Tarkin Other Significant Containers Contributing to Geath St	At Not resulting in the or	nderlying cause gi	on in rait i.			Probably 4X Unknown
000	aw requir ts been si 2 should I	plete					24a. Was ai		autopsy findings available
ž	Physician: The lav this certificate has al director, page 2 a	Completed					autops perforn 1 □ Yes 2	ned? deat	to completion of cause of h? Yes 2 □No
Ĭ Ĭ	Attending Physician: r death. ector: After this certifics by the funeral director, p	Be	25. Was case referred to medical examiner?  1  Yes 2  No  Hospital: 1 Inpatie		Ott	26. Place of Death (C	•		HOGDTOD
Division of Vital	ding Phy h. After this funeral d	ŭ.	27. Manner of Death 28a. Date of Inju		IL SUIDOA	ry at 280		w injury occurred	Specify) HOSPICE
sior	Attendin er death. ector: Af by the fur	catio	2 Accident investigation		M 1 🗆	lYes 2 □No			
<u> </u>	l or Attene after death Director: I in by the	Certification: To	4 Homicide determined 28e. Place of Inju-	ury - At home, farm, str c. <i>(Specify)</i>	eet, factory, office	28f	f. Location (St. City or Town	reet and Number o n, State)	r Rural Route Number,
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	To the Hospital or A within 24 hours after To the Funeral Directory completely filled in by	Medical	one) 2   Medical Examiner. On the basis of and manner sta		29c. Licens			9d. Date signed (M	
	<b>5</b> ≥ <b>5</b> 8	_	200. Olgitaldre and title of certifier			4372(	-   -	7/16	
	2		30. Name and address of person who completed cause of d	eath (Item 23a) (Type,				1 1	
	5			ULANEY VALI ar's Signature	LEY RD.	TIMONIUM, N	MD 2109	13	
	Sta Registra	-	or. Sale filed (Moriti, Day, real)	ars Signature	and I				
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			For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of h		Mental Hy	giene Reg. No.2	800	23543
	Physici /Medic		1. Decadent's Name (First, Middle ES+ELLe	B. Wo	Triecho	nski		2. Date of D Month	eath Gay	O <sup>Year</sup>	3. Time of Death
	Examir		4a. Facility Name (If not institution RIVERVILW (	are cen	ter	ES2			į į	Sulph	1 more
1	Funeral Director		5. Social Security Number 214-14-9368  Usual Residence of Decedent	6. Sex 7. A 1 □ M 2 1 F	Age (In yrs. last birthday) 88 Yrs.	Months Days	Hours Min.		,1919	Mary	place (State or Foreign otry) Land
	th the Maryland or 28a-f show e notified at	Director	Md. 10b. County Md. Balti  10e. Street and Number		10c. City, Town or Lo	10f. Zip Code			10g. Citizen o	f What Cou	0d. Inside City Limits 1 □ Yes 2√20No  ntry?
920	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by Funeral Director	904 Virginia  11. Marital Status  1 Never Married 2 Marr 3 X Widowed 4 Divorced	12. Was Deceden Armed Forces	No	Was Decedent of Hif Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or N to Rican, etc.)	BI	A. ace - Americ lack, White, cify: Whi	etc.
121215-0036	filed within 72 ho Hygiene. ther than "natur ent, the Medical I	Completed	15. Deceden (Specify only highest Elementary/Secondary (0-12) 8 th 17. Father's Name (First, Middle,	completed) College (1-4a)	r 5+) (Give life. B &	dent's Usual Occup e kind of work done DO NOT use retire	pation during most of wo d)  18. Mother's Na		16b. Kind of Herman	n's B	akery unk)
Baltimore, Maryland	es 1 and 2 should be of Health and Mental f Item 27 Is marked o r other traumatic eve	To Be	19a. Informant's Name/Relations  Wendell Shiff  20a. Method of Disposition  1X Burial 2 Cremation  4 Donation 5 Other (S	hip ( <i>Type. Print</i> )  Elett / P. 3 □Removal from Stat	O . A . 80 E		and Number or R	ural Route Num Baltin Date	nore, 1	n, State, Zip Md . 2	Code)
Baltir	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service		2	2. Name and Addre	ess of Facilit A C	zorows	ki Fur	neral	Home, PA Md. 21222
	Physician /Medical		23a. Part1. Enter the diseas or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Wm	ed the death. Do not en line plication plication is a consequence of):		ng, such as cardia				Approximate Interval Between Onset and Death
8760,	Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b	is a consequence of):		Ar	prov.	This series	John Jan	n)
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 Fetal death 3 at time of death 5	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	, /,	1-1:5		Date of deliv	ery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant condition	ons contributing to death	but not resulting in the u	underlying cause gl	ven în Part I.		tobacco use co	ontribute to t 3 ☐ Pro	he cause of death? bably 4 □Unknown
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n or Vital	ding Physician: The n. The After this certificate hit funeral director, page	on: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pendin	Hospital: 1 ☐ Inpa  28a. Date of In  (Month, I		of 28c. Inju	ner: 4 Nursing I ry at rk?		sidence 6 🗆 C		fy)
Division	or Attendition of Att	Certification:	2 Accident investig 3 Suicide 6 Could i 4 Homicide determ	not be lined 28e. Place of in building,	njury - At home, farm, st etc. (Specify)	reet, factory, office	]Yes 2 MiNo	28f. Location City or To	119/11/19	Ave,	BULLINWING
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only 2 Medical one)	ng Physician: To the bes Examiner: On the basis and manner:	of examination and/or in	th occurred at the to envestigation, in my 29c. Licens	opinion, death occ	e, and due to the curred at the time	e, date and plac	e, and due	to the cause(s)
	o in vita		29b. Signature and title of certifle	E.	MD	D	61900	7	29d. Date sig	21/2	100 8
	1		30. Name and address of person	Ebo, 1124	- Mace A	reint)	Bultin	nore,	MD	2122	1
	Sta Regista		31. Date filed (Month, Day, Year)	2008 32. Egis	strar's Signature	-					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend PI line a-c, perMD, g88be7/122/08 Theath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 50 PM JAMES 2008 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOPKING BAYVIEW MEDICAL CENTER BALTI MORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March | 16,1953 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Sex № M 2□ F **Funeral** 55 220-84-6731 Korea Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits show items 23a or 28a-f shover rust be notified at 1 ☐ Yes 2 No Director Maryland Ellicott City Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21042 **USA** 4265 Hermitage Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married d 2 should be filed within 72 hours after the and Mental Hygiene. 27 is marked other than "natural", or it traumatic event, It when the least the manual traumatic event, It was also the traumatic event, It was also the least the manual traumatic event. Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify Specify: Asian þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Yim Jong Lee ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra Sue Yim, Wife 4265 Hermitage Drive Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/23/08 Metro Crematory Inc. Baltimore, Maryland Name and Address of Facility Home P.A. 21. Signature of Funeral Service Licensee SICe. Kim MacLeod 301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Herniation Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 3 days /Medical Due to (or 3 a consequence of) week Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and the burial-transi Exami Due to (or as a consequence of) Box 68760, pe Physician/Medical use as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year signed by the and be detached for 5 Other (specify) P.O. I □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ج 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an autopsy 2 INO 1 ☐ Yes 2 ☐ No of Vital 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attending 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 4940 EASTERN ALENUE BACTIMONE MD 21724 ELISABETH MARSH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 2 2 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** lipe 48 01 13 . 02 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1 **x** M 2 □ F Months Director El Salvador February 5, 1945 63 577-66-1431 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 ☐ Yes 2 X No Directo Maryland Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7711 Ora Court 20770 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:1965-1971 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ▼ Yes 2□ No Specify: El Salvador Specify: Hispanic þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NASA 5+ Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ို Miguel S. Flores Paula Amaya 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7711 Ora Court, Greenbelt, Maryland 20770 Gladys Flores-Amaya - Wife 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Cheltenham Maryland State
Veterans Cemetery 1 x Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/11/2008 Cheltenham, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final 30 minutes disease or condition resulting in death) Due to (or as a consequence of f): mer quertially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medica only one) 1 Yes 2 No 6 ☐Other (Specify) After this Residence

**Physician** /Medical Examiner The law requires that the death certificate be executed physician and s the burial-transit Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Certification: To

					1 🗆 🗅
				26. Place of Death (C	heck o
Hospital:	1 Inpatient	2 ER/Outpatient	3□ DOA	Other: 4 Nursing Home	5 🗆

7.	Man er of Death		28
	1 🔀 Natural	5 Pending	
	2 Accident	investigation	
	3 Suicide	6 ☐ Could not be	-

Natural	5 Pending
Accident	investigation
Suicide	6 ☐ Could not be determined
imomicide	

(Check only

31. Date filed /Mor.

28a. Date of Injury (Month, Day Year)		28b. Time of Injury		1
			М	
286	Place of injury - At he	ome form stree	t fact	OF

Work?	
1 ☐ Yes	2 🗆 No

	28d.	Describe	how	injury	occurred	
ю						

4 ∐ Homicide	determined	building, etc. (Specify)	
29a. Certifier	1 Certifying Physi	cian: To the best of my knowledge, death occurred at the	tim

-		1		
1 Certifying Physic	ian: To the best of my knowledge, death occurred at the time, date	e and place, a	and due to the cause(s) and manner as stated.	
2 Medical Evamina	r: On the basis of examination and/or investigation, in my opinion,	doath accurr	red at the time, date and place, and due to the course	(0)
Z   Medical Examine	. Of the basis of examination and/or investigation, in my opinion,	deali occurr	red at the time, date and place, and due to the cause	(5)

29b. Signature	and title of certifier	7
	-1/	. //
	Horse	160
	100000	100

LOC: LIO	orioo rii					
7	2	2	1	1	1	

29d. Dat	e signea (	Month, D	ay, rear	,
	07	102	10	a

30. Name and addre	ess of person who comp	leted cause of death	(Item 23a) (Type, Print)
THEMAS	KO MD	8100	Goodleck

State Registra

Medical

8100 Goodlick gistrar's Signatur

	_	_		
_		_	_	

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician:

after death.

I Director: Aid in by the fu

within 24 hours at To the Funeral I

20+1

		1 - State Registrar  1. Decedent's Name (First, Middle, Las		L.,gc	oz, you	tifica	te or i	Death		2. Date of De		800	235	
Physic /Medi			andlen							July 1	4, Day 200		1328	М
Exami	ner	4a. Facility Name (If not institution, give 319 Hammond St.	street and number)					cocation o				nty of Death .egany		
Funeral Director		210-04-0701	ex 7. Ag <b>Ex</b> M 2□ F 5		last birthday) Yrs.	If Und Months	er 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Dec. 6	v. Year)	T 7 - GOI	nplace (State or I	oreigi iia
Maryland f show led at	tor	Usual Residence of Decedent  10a. State 10b. County  MD. Allegany	7	1	y, Town or Lo	cation							10d. Inside City 1 Yes 2	
h with the 23a or 28a st be noti	Funeral Director	10e. Street and Number 311 Pratt St.					ip Code 1540				10g. Citizen United			
be filed within 72 hours after death with the Maryland ttal Hyglene. ed other than "natural", or Items 23a or 28a-f show event, the Medikal Examiner must be notified at	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 TY es 2 If Yes, Give Year or Dates:			r Yes, sp	edent of Hi ecify Cuba 2/21/No	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No Rican, etc.)	E	Race - Amer Black, White cify: W		
I within 72 ho jiene. <b>r than "natu</b> <b>the Medical</b>	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or s	5+)		kind of v	ual Occupa ork done o use retired CTOT	ation luring most )	of workin	g	16b. Kind o	f Business/I litio	•	
should be filed and Mental Hygie marked other imatic event, It	To Be C	17. Father's Name ( <i>First, Middle, Last</i> )  Robert Brane	dlen					18. Mother	r's Name Mary	(First, Middle, Jack		name)		
2 s In ar Is Irau		19a. Informant's Name/Relationship (7 Mary Brandlen/ mo			1	-				Route Numb	-	_	ip Code) and 2152	:3
permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other t		20a. Method of Disposition  1XXXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		_ 0	Place of Dispo emetery, crer tomac	natory o	other plac			18/ 8	20c. Location Keyse	-	rown, State st Virgi	ni.
permit. Departimonts any inj		21. Signature of Funeral Service Licen		el				s of Facility	DOa.	l Funei ternpoi			21562	
Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only in Immediate Cause (Final disease or condition resulting in death)	olications that caused one cause on each li a. ASCVHD Due to (or as			er the m	ode of dyin	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Betwe Onset and De	en ath
ficate be exceuted physician and is the burlal-ransit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as  c. Due to (or as  d.	· ·	,									
law requires that the death certifica as been signed by the attending pt 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 25 No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 🗌 Feta	il death 3 □	Ectopic Other (	pregnancy specify)					Date of deli Month	very Day Ye	ar
uires that signed by Id be deta	by	Part II. Other significant conditions of	ontributing to death b	ut not res	ulting in the u	nderlying	cause give	en in Part I.		23e. Did t		. 1	the cause of dea	
The la ate has page 2	Completed									24a. Was auto perfo 1 Yes		prior to death?	topsy findings av completion of cau 2  No	ailable se of
Physiclan: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  Yes 2□ No	Hospital: 1 ☐ Inpatie	ent 2 🗆	ER/Outpatien	it 3□[	OOA Othe	26. Place	of Death	(Check only o	dence 6 🗆	Other (Spec	Friend's	3
To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral directorial.		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da		28b. Time of Injury		28c. Injury Work	vat :? Yes 2∐1	2	8d. Describe	how injury oc	curred	Home	
tal or Atters safter de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inj building, et	ury - At ho c. (Specif	ome, farm, str y)	eet, facto	ory, office		2	8f. Location ( City or To	Street and Nu wn, State)	mber or Ru	ral Route Numbe	эr,
Hospi 24 hour Funer etely fill	edical	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	f examina	wledge, deat tion and/or in	n occurre vestigati	d at the tin on, in my o	ne, date an pinion, dea	d place, a th occurre	and due to the ed at the time,	cause(s) and date and pla	manner as ce, and due	stated. to the cause(s)	
To the within To the comple	Wec Wec	29b. Signature and title of certifier	Site marrier st		_	2	9c. License				29d. Date siç July	ned (Monti		
	6	30. Nam and ridress of person who of Dr. Paul Snow, 12					MD.	21502		-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMENDED PER FH #17 7/10/68 rtificate of Death CCHD AS Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Burtz orman 28 0955 AM 2000 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Move Social Security Number Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Vear 1**X**M 2□ F Months Days Hours 76 220-32-9115 Director June 20 1932 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Caroline Henderson 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 26105 Bee Tree Road 21640 Funeral USA permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nource any injury or other traumatic conce. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 X Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify White ð 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 08 auto repair & tow truck operator auto industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown Norman Blackiston Martha Bartz Blackiston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26105 Bee Tree Road; Henderson, Maryland 21640 Margurette Bartz/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) July 2 2008 Greensboro Cemetery Greensboro, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial /Medical Due to ( r as a consequence of): Examiner Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse gience of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No page 2 s 24a. Was an autopsy certificate perform 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes this funeral 27. Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Amedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29b. Signature and title of certifie 29c. License number 0 29d. Date signed (Month. Dav. Year)

State Registrar . Name and address of person who complete

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8 2008

DHMH 17 Rev 1/2001

Greene

cause of death (Item 23a) (Type, Print)

egistrar's Signature

08-05381 Kyle Boltinghouse

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2008	23	54	8
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yle Bollinghoo		1- For State Registrar Certificate of Death	Mental Hygiene	Reg. No.	200	8 2354
Physici Medical Exami		Decedent's Name (First, Middle,Last)	2. Date of [ Month	eath)	Year	3. Time of Death
ne-wear Exam	IIICI	Kyle Kathryn Boltinghouse  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Loc	Month July 13		County of Death	1736 hrs
		2246 Washington Avenue #101 Silver Spring			ontgomery	
Funeral Director	14	217-56-3946 1 Months Days	Hours Min	Birth(MM/D	951 9. Birtl Poreigi Cou	
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		·		10d. Inside City Limits
daryland 28a-f show 1 at once.	ţo	MD Montgomery Silver Spring				1 Yes 2 No
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Fel and Mental Hygiquie. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	al Director	10e. Street and Number 10f. Zip Code 2246 Washington Avenue #101 2091	0		en of What Coun	try?
eath wi	Funeral		nic Origin? ( Specify Yes or exican, Puerto Rican, etc.)	No- 1	<ol> <li>Race - Americ White, etc.</li> </ol>	can Indian, Black,
after d	by Ft	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No sg	pecify:	s	pecify: Wh	nite
hours "natur		45.5	(Give kind of work done NOT use retired)	16b. Kii	nd of Business/Ir	ndustry
036 tthin 72 ne.	Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)  Homemaker			Own Hon	ne
215-0036 be filed within 7 mal Hygiene. rked other than ent, the Medica	So	17. Father's Name (First, Middle, Last)	Mother's Name (First, Midd	e, Maiden S	urname)	
2121 2121 2uld be f Mental marked ic event,	To Be	Llyle Boltinghouse  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and	Margaret S	mith		
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ore,   S   and of Heal If item		20a. Method of Disposition  20b. Place of Disposition (Name of cemete crematory or other place)			ocation - City or	
Baltimore, permit. Pages I an Department of Hea Important: If Itel		4 Donation 5 Other Specify Chesapeake Crem	1 ' '	08 B∈	ltsvil	le,Md
Bal permi Depar Impo		21. Signature of Funeral Service Licensee 22. Name and Address of FHTT P D. R. 9241 Columb	INALDI FUN	ERAL	SERVIC	E,PA
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such fallure. List only one cause on each line.	th as cardiac or respiratory	arrest, shoc	k, or heart	Approximate Interval
'Medical xaminer	1	Immediate Cause (Final disease a Mixed drug intoxication (dipher	nhydramine &	fluox	etine)	Between Onset and Death
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	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
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760, frate be executed physician and the burial - transit	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			Date of delivery	
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Box 68' te death certifi the attending ted for use as	Physician	1 Yes 2 No 9 V Unknown 9 Unknown 9 Unknown Other (Specify)				
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Division of Vital Records, P.O. ret or Attending Physician: The law requires that the stater death.  In Director: After this certificate has been signed by ted in by the funeral director, page 2 should be detach	ωl	25. Was case referred to medical 26.Place of D	1 Ye Death (Check only one)	s 2 🗸 No	1 Yes	8 2 No
hysici	10 B	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	er. 4 Nursing Home 5		ce 6 🗸 Other:	
n of ading I		27. Manner of Death  28a. Date of Injury (Month, Day, Year)  1 Natural 5 Pending Relation 1 Yes	Work? 28d Describent	e how injury ional	occurred sul	ject losed on
r After r After ter dear irector in by th	licat	2 Accident Investigation   Fnd 7/13/08 Fnd 5:20 pm 28e. Place of Injury - At home, farm, street, factory, office building	medica	tions		
Divinal of ours affilted i	Certification:	4 Homicide determined (Specify) residence	#1, or Town	i State) 2 Iver	246 Wash Spring,	al Route Number, City Lington Ave
To the Hovithin 24 I	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date are cone)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deal and manner stated.	ind place, and due to the ca	ause(s) and	manner as state	d.
S-Par	Ž	29b. Signature and title of certifier  29c. License nur			te signed (Mon	th, Day, Year)
	-	30. Name and address of person who completed cause of death (Item 23a)		July 1	4, 2008	
		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltir	more, MD 21201			
Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature				
OHMH 17 Rev 1/20	_	OPIGINAL				
CME 2006		OCME				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 23549 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year . Month Day Jul 2:55 A M Ruthann Coggins Bardes 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Renaissance Gardens - Riderwood Nursing Home Silver Spring Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 X F Director Connecticut 80 August 4, 1927 292-22-5730 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c, City, Town or Location is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. I health and Mental Hygiene riems 23a or 28a-f show 72 is marked other than "natural", or items 23a or 28a-f show cother traumatic event, the Maries Francisca must be notified at 1 ☐ Yes 2 K No Funeral Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 3124 Gracefield Road, #405 20904 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: Completed by 3 Widowed 4 Divorced Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Textiles Fashion Designer Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Unascertainable) ည Herbert Lawrence Coggins Ruth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a
Important: If item 27 is
any injury or other trai Lawrence H. Carmel - Personal Rep. 66 Pleasant Ridge Road, Harrison, New York 10528 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 S Cremation 3 Removal from State 07/21/2008 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory Brentwood, Maryland 21. Signatur Fune al Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications tha shock, or heart failure. List only one cause of Immediate Cause (Final Atria Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off: CUSC The law requires that the death certificate be executed Degenerative Due to (or as a consequence of) physician Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 2 🗹 No 1 🗆 Yes 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? Yes 2 No Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending after death. Director: Al 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

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To the Hospital within 24 hours a To the Funeral D

completely

29a. Certifier

(Check only one)

29b. Signature and title of certifier

oveen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Figistrar's Signature

Medical

State Registrar

S5Am

DoB

DHMH 17 Rev 1/2001

LOVEEN J. PUTHUMANA 3110 GRACEFIELD ROAD SILVERSPRING, MD 20904

🔛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** June 30 Lorraine Grady Barrett /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Doctors Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth Nov. 20, 1943 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 250 F 212-20-1339 94 MarvI and Yrs Director Usual Residence of Decedent 10c. City, Town or Location Lanham 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-1 shov ury or other traumatic event, the "actical Examinat" and be notified at Prince George's Maryland Director 1 ☐Yes 2 ☐No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6141 Naval Avenue 20706 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Completed by Specify. White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (9,12) College (1-4or 5+) Housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Jackson Grady Georgia Lee Clatterbuck ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 s Department of Health as Important: If item 27 is any injury or other trau Ronald J. Collins -nephew 4230 Robinson Road Huntingtown, Maryland 20639 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Fort Lincoln Cemetery 7/7/2008 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licenses Donald Vie Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** diac /Medical Examiner andio Vascular Distan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dusto (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a 1 be detached f P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>ک</u> The law requires 2 No 3 Probably 4 Unknown After this certificate has been s funeral director, page 2 should Completed 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?\* Yes 21 No 1 ☐ Yes 2 No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 ☐ Pending investigation ours after death. neral Director: A filled in by the fu r death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the

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29b. Signatu

Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 29c. License number

D20108

29d. Date signed (Month, Day, Year)

Tox Ln, Ste. 222, Bowie, m. D. 20715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23551 1 - State Registrar AMEND#1perMD7/10/08, BMW, MbCo Certificate of Death FREDERICK 1. Decedent's Name (First, Middle, Last) KEITH 3. Time of Death 2. Date of Death Month Year **Physician** KEITH FRERICK BYRD 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY Silver Spring Holy Cross Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day. Year) | Apr. 27, 1953 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Maryland 1 M 2 □ F 215-60-6315 55 Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.

other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 10b. County 1 ☐ Yes 2 ☑ No Silver Spring Director MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be re 20904 U.S.A. 13400 Clifton Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Yes W No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FCI Contractors Manager 2 yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental Int: If Item 27 is marked of Jacqueline Hill Frederick D. Byrd 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13400 Clifton Rd, Silver Spring, MD 20904 Teresa Byrd (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition p rmit. Pages
D-partment of
In portant: If it
any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cem 7/7/08 Silver Spring,MD Q /5 ☐ Other (Specify) 4 ☐ Donation 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature Funeral Service Licens 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the discrese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail ire. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, any, but high to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician Physician/Medical the attending philor use as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 4☐Pregnant at time of death the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has I autopsy performed? Yes 2121No page 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No ို 2 ER/Outpatient 3 DOA 1 Inpatient Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division or Vital Records, P.O. Box 68760 within 24 hours a

To the Funeral I

completely filled To the Hospital

> State Registrar

29b. Signature and title of certifier

Day, Year)

0 7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

DHMH 17 Rev 1/2001

distrar's Signature

123001

29d. Date signed (Month, Day, Year)

SPRING MD

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	State of Maryland				ınd Mer	ntal Hy	giene		
			1 - State Registrar		Cei	rtificate of L	Death			Reg. No.	2008	2355
學	Dhysisi		1. Decedent's Name (First, Middle, Las	st)					Date of Dea Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Truxtun Ric	h Baldwin					uly	7,	2008	6:20 а. м
>	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or	Location o	f Death			County of Death	
			Manor Care Cheven		act hirthday)	Chevy If Under 1 Year	Chase If Under 2		Date of Birt		ontgome	ry  place (State or Foreign
	Funeral		1 1	TSFM 2□ F	Yrs.	Months Days	Hours	Min.	(Month, Da	y, Year)	Cou	w York
	Director	ł	305-28-3327 Usual Residence of Decedent	78				ric	ıy 13,	173	O NC	
	ylanc now at		10a. State 10b. County	10c. City	, Town or Lo	cation						10d. Inside City Limits
	a-f st	ctor	D.C. None	e Wa	shing	ton, D.C.						1 ⊊Yes 2 □ No
	or 28 e not	Director	10e. Street and Number			10f. Zip Code				10g. Citiz	en of What Cou	ıntry?
	23a ust b	<u>a</u>	4420 Brandywine			20016				1.	U.S.A	See a beatle
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Orig an, Mexican	gin? (Specify i, Puerto Ric	Yes or No an, etc.)	-   1	<ol> <li>Race - Amer Black, White</li> </ol>	
0000	", or i	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 21 No	Specify:				Specify: Wh:	ite
ξ	hour tural	ed t	15. Decedent's Ed		16a. Deced	dent's Usual Occup	ation			16b. Kir	d of Business/I	ndustry
Ċ	in 72 n "na Aedio	Completed	(Specify only highest gra Elementary/Secondary (0-12)		(Give life. l	kind of work done of DO NOT use retired	during most d)	t of working				
7	yiene r tha	E	Elementary/Secondary (0-12)	5+	Ind	ustrial E	ngine	er		U.S.	Dept.	of Defense
2	e filed al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last,				18. Mothe	r's Name (F	irst, Middle,	, Maiden S	Surname)	
<u>a</u>	Menta	10	Irving Willard	Baldwin				elen R				
<u>a</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hylgiene. Department of Health and Mental Hylgiene. Important: If fiem 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (	Type. Print)	19b. Mailir	ng Address (Street	and Numbe	r or Rural R	N.W.	er, City or	Town, State, Z	ïp Code)
.` ``	and ealth m 27		Jacqueline Baldwi			Brandywi ington, I	56.			000 100	nation City or 7	Fanna Stata
ב	ges 1 t of H If ite or otl		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	emetery, crei	osition ( <i>Nam</i> e of matory or other place Dlitan	ce)	Date		20¢. Lo	cation - City or T	rown, State
Daltillion	. Рас tment tant: jury		4 ☐ Donation 5 ☐ Other (Specif	y) C	remato	rv	*	7-8-08				Virginia
0	permit Depar Impor any In once.		21. Signature of Funeral Service Licer	1See		2. Name and Addres						D 0
	<u> </u>		17 engel	Jerl		222 Wisco					ington,	D.C. Approximate
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	. Do not ent	er the mode of dyin	ig, such as	cardiac or re	spiratory a	iresi,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. <u>Possi</u>	ble	Sepsis						
	/Medical Examiner		1	Due to (of as a consequ	ience of):							
		6	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a consequ	ience of):							
)	ited nsit	nin	Cause (Disease or injury		,							
	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	C	ience of):							
00/0	cate be executed physician and the burial-transit	dical	(	d								
Ď	tificat g phy as th	edi										
Š	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy	,			2	3d. Date of deli	•
	deat le att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de		Other (specify)	<u></u>				Month	Day Year
5	at the by th	hys	9 Unknown						00- Did 4			Ab a private of death ?
ń	es the igned	by	Part II. Other significant conditions	contributing to death but not resu	ilting in the u	nderlying cause giv	en in Part I.			Yes 2		the cause of death?  bably 4 Unknown
colds,	requir	ted	Chronic To	mal dise	asi					165 2	] 140 3 [] F II	Sbably 4201KHOWH
2	law las be	ple	Demen	tia.					24a. Was auto	psy	prior to c	topsy findings available completion of cause of
=	ate h	Completed							1□ Yes	2 No	death? 1 ☐ Yes	2 <b>/≅</b> _No
2	certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		oth 3D DOA Oth	or:	of Death (C				
5	Phys this c	မ	1 Yes 2 No	28a. Date of Injury	ER/Outpatier 28b. Time o	" OLI DON	4120(40		5 Resi		Other (Spec	cify)
5	After After funer	io	1 Matural 5 Pending	(Month, Day Year)	Injury	Wor	k? Yes 2∐1		. Describe	now injury	Occurred	
2	death ctor: / the	icat	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of injury - At ho	me, farm, str				Location (	Street and	d Number or Ru	ral Route Number,
2	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	4 Homicide determined	building, etc. (Specify	1)				City or To	wn, State)	)	
	spita ours neral		29a. Certifier 1 Certifying Ph	nysician: To the best of my know	wledge, deat	h occurred at the tir	me, date an	nd place, and	due to the	cause(s)	and manner as	stated.
	le Ho 1 24 h le Fu sletely	Medical	(Check only 2 Medical Examone)	niner: On the basis of examina and manner stated.	tion and/or in	ivestigation, in my o	opinion, dea	ath occurred	at the time,	, date and	place, and due	to the cause(s)
	withir To th	Me	29b. Signature and title of certifier	1298		29c. Licens	e number			29d. Dat	e signed (Montl	n, Day, Year)
)	2		•			D00	545	566		71	7/08	
			30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)						
				govilli 9801	Crear	gia for	nu	一件	17,51	ever	sprina	MD20902
	Sta		31. Date filed (Month, Day, Year)	() 3 Régistrar's Signa	ture	2005 0					4 /	MDZQQ2
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DHMH 17 Rev 1/2001

Registrar

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JUL

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		,	ingistial II — I have F	ificate of Death	Reg	2008	23554
	Physicia		1. Decedent's Name (First, Middle, Last)  Dorothy Viola Bridget		2. Date of Death Month July 6,	Day Year 2008	3. Time of Death 4:21 a M
	/Medic Examin			4b. City, Town, or Location of Death	July 0,	4c. County of Death	T.21 d
أميو			Vantage House Health Care Center	Columbia		Howard	
	Funeral		1 M 2 X F	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,		lace (State or Foreign try)
	Director		Usual Residence of Decedent		July 7,	1922   Wash	ington, DC
	yland now		10a. State 10b. County 10c. City, Town or Locat	tion		10	0d. Inside City Limits
	a-fsh	ctor	Maryland Howard Col	umbia			1 ∐Yes 2 🔯 No
	or 28	Director	10e. Street and Number	10f, Zip Code	100	g. Citizen of What Coun	try?
	ath w		5400 Vantage Point Road	21044		USA	
36	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show droit Evan in critist be in difficulat	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21x No	s Decedent of Hispanic Origin? (Sp res, specify Cuban, Mexican, Puerto ☑Yes 2 <b>;</b> ☑No <i>Sp</i> ec <i>ify:</i>	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, e	etc.
5-0036	thour atural	ted I	15. Decedent's Education 16a. Deceder	nt's Usual Occupation	16	Bb. Kind of Business/Ind	White dustry
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21	ed with	Con		maker		Own Home	
Maryland	be file	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	,	
<u>≅</u>	ould Mer arke	은	Leonard E. Beane		y Palmer		
g Z	d 2 sh Ith and It is m traum		19a. Informant's Name/Relationship (Type. Print)  Michael S. Bridget/Son  19b. Mailing n	Address (Street and Number or Run 801 Nicholson Lar	ne. Apt	City or Town, State, Zip Rockvill	Code) le. MD 20851
ē,	s 1 and of Health item 27 other to		20a. Method of Disposition  20b. Place of Disposition  cemetery, cremat			Oc. Location - City or To	
Baltimore,	e = = 5		LANGURIA 2 LI Cremation 3 LI Hemoval from State 1	aven Cemetery	11y 8 2008 S	dilesen Comi	Ma
aĦ	permit. Par Departmen Important: any injury			Name and Address of Facility			ng, Maryland
n	9 9 <b>5 6 9</b>	7 17	Joseph Nog 500	O University Blvd	. W., Si	lver Spring	MD 20901
	tificate be executed  By Medical  By American and as the burial-transit as the burial-tr	al Examiner	23a. Part / Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence or):  Due to (or as a consequence of):	white typesone contact of the sounder of the sounde	DE II		Approximate Interval Between Onset and Death
. Box	death certi e attending d for use a	Physician/Medical		ectopic pregnancy Other (specify)		23d. Date of delive	ery Day Year
J.	that the ed by detac		Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did toba	cco use contribute to the	ie cause of death?
ďs,	requires that the	d by			1 □ Yes	2 No 3 Prob	ably 4 🗌 Unknown
Hecord	law req as beel 2 shou	Completed			24a. Was an	24b. Were auto	psy findings available
	The la ate has	duo			autopsy performe	prior to cor	mpletion of cause of
VItal	ian: 7	a)	25. Was case referred to medical	26. Place of Deat	1 L Yes 27 h (Check only one)	No 1 □Yes	2 No
O T <	ding Physician: The I h. After this certificate ha funeral director, page	To B	examiner?  1   Yes   2   No   Hospital: 1   Inpatient 2   ER/Outpatient	Otto		ce 6 🗍 Other (Specify	y)
_	ng Pl	ü	27. Manner of Death 28a. Date of Injury (Month, Day, Year)  28b. Time of Injury (Month, Day, Year)	28c. Injury at Work?	28d. Describe how	injury occurred	
sion	Attending ir death. ector: Afte by the fune	cati	2 Accident investigation	M 1 □Yes 2 □No			
Š	or At after o Direct in by	Certification:	4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  28e. Place of Injury - At home, farm, street building, etc. (Specify)	, factory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	I Route Number,
_	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	Medical Co	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investigation and the basis of examination and the basis of exami	ccurred at the time, date and place, stigation, in my opinion, death occur	and due to the cau	use(s) and manner as s e and place, and due to	tated. the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month,	Day, Year)
	9		Moderate - 101 N	D5142.1	7	17/08	
	Q		30. Name and address of person who completed cause of death (Item 23a) (Type, Prince 23a)				
			Willie B. MVEMBA 415 commos	nweath AV, Co	Wordy	le ens	21228
	Sta Registra		31. Date filed (Month, Day, Year)  Registrar's Signature			4	

# Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		Please	e Type or Prin								e.	
		For State	State of Ma	iryiariu /		rtificate of		vientai H		000		
	7	Registrar  1. Decedent's Name (First, Middle, L	.ast)		001	inoute or	Death	2. Date of D	Reg. N	°.201	18 .	2355 E
Physici /Medi		THOMAS RICHAR						Month JULY	02,	ay Ye 2008	ear	11 A <sup>M</sup>
Examir	ner	4a. Facility Name (If not institution, g	ŕ				or Location of Death	1		c. County of I		
Funeral			DRIVE Sex 7. Age	(In yrs. last	birthdav)	EDGEWAT	LK If Under 24 Hrs.	8 Date of B		ANNE A		(State or Foreign
Director		213 42 6194 Usual Residence of Decedent	1 M 2 □ F	64	Yrs.	Months Days	Hours Min.	8. Date of B (Month, D SEPT.(	03, Year	943 W	Country)	IGTON, D.C.
ow at		10a. State 10b. County		10c. City, To	own or Lo	cation	-				10d.	Inside City Limits
72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	Director	MARYLAND ANNE A	RUNDEL	EDGEV	VATER							1 □ Yes 2 □ No
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death v	eral	3864 TWIN OAKS			1.0	21037				TED ST.		
ter de item iner r	Funeral	11. Marital Status 1 ☐ Never Married 2 Married	12. Was Decedent E Armed Forces? 1 X Yes 2 □ N		13. \	Was Decedent of F f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puert	pecify Yes or Non Rican, etc.)	0-	14. Race - / Black, \	American White, etc.	ndian,
ours after c ral', or iter Examiner	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 1 Year or Dates:	965-71		l∐Yes 2¶X No	Specify:			Specify:	WHITE	
n 72 hours "natural"; edical Exa	Completed	15. Decedent's I (Specify only highest g		11	6a. Deced	lent's Usual Occup	oation during most of worl d)	kina	16b. l	Kind of Busin	ess/Indust	ry
withir ene. than	교	Elementary/Secondary (0-12)	College (1-4or 5-	<del>-</del> -)		oo not use retire sion Mana		3	11+-	ility (	Const	ruction
e filed al Hygid other vent, th		17. Father's Name (First, Middle, Las	st)				18. Mother's Nam	e (First, Middle				Tucción
ild be fental rked c	To Be	JOHN KENNETH BI	EARD, JR.					TWYNHAN		,		
2 should and Men Is marke aumatic		19a. Informant's Name/Relationship	(Type. Print)	1	9b. Mailin	g Address (Street	and Number or Ru			or Town, Sta	te, Zip Co	de)
and lealth m 27 her tr		PAMELA R. BEARD	(WIFE)			TWIN OAL			TER	,MD. 2	1037	
permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important; If item 27 Is marked other any injury or other traumatic event, once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	ceme	etery, cren	sition (Name of natory or other plac	ce)	Date	20c. L	_ocation - City	y or Town,	State
nit. Pa artmer ortant injury	}	4 □ Donation 5 □ other (Special Signature of Juneral Service Do	eify)	KALAS		MATORY  . Name and Addre		4-2008		GEWATE		
Depa Impo any is		1/2///			1		MONS_ISLA	ORGE P.		LAS FUI		HOME • 21037
44		23 a. Part1. Enter the disease, or cor shock, or eart failure. List only	mplications that caused	the death. D						N3EWA I I	Ap	proximate
Physician		Impediate ause (Final disease or condition	ALETAS	MAS	C	BIA	MER (	ANTI	5R		Pr	erval Between liset and Daath
/Medical Examiner		resulting in death)	Due to (or as a	consequenc	e of):		EPO.	41100				10.101-
Lxammer	_	Sequentially list conditions,	b. — Due to cores e	and a more	Data in a							
nted nsit	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Line it (3 79 9	nonsecue; x	e-ory:							
oe executed cian and ourial-transit	Еха	that initiated events resulting in death) Last	c Due to (or as a	consequenc	e of):							
ate be nysicia he bur	ical		d									
ertifica ing ph e as tl	Med	IF FEMALE:										
eath certificate b attending physic for use as the bu	Physician/Medica	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1□Live birth 2	⊇ ☐ Fetal dea		Ectopic pregnancy	у			23d. Date of Month	delivery Day	/ Year
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime or death	5	Other (specify) _						
s that ned b e deta	by Pł	Part II. Other significant conditions	contributing to death but	t not resulting	j in the un	derlying cause giv	en in Part I.	23e. Did	tobacco	use contribut	te to the c	ause of death?
w requires that the de been signed by the should be detached	ted b							10	Yes 2	2□ No 3 <b>)</b>	Probably	4 □Unknown
e law n has be e 2 sh	Completed							24a. Was		24b. Wer	e autopsy	findings available
The icate i								perf 1□ Yes	ormed? 2 N	deat	h?	No
siclar certif	Be C	25. Was case referred to medical examiner?  1 ☐ Yes ♣☐ No	Hospital:		D. 4414	3 DOA Oth	26. Place of Deat	. /				
a Phy er this eral di	2 1	27. Manner of Tath	1 ☐ Inpatien 28a. Date of Injury	/ 285	. Time of	28c. Injur Worl	4 LI Nursing Ho	ome 5 Res 28d. Describe		6 □Other (	Specify)	
ath. arth. rr: Aft	atio	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day on	Year)	Injury		k? Yes 2 □ No					
r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		y - At home, (Specify)	farm, stre	et, factory, office		28f. Location (			r Rural Ro	ute Number,
pital c urs af eral D		One Contifier 45 October 1										
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	edical	29a. Certifier  (Check only one)  1 Certifying P  Medical Exa	hysician: To the best of miner: On the basis of and manner state	examination :	ge, death and/or inv	occurred at the tir estigation, in my o	me, date and place, ppinion, death occur	and due to the red at the time	cause(s , date ar	s) and manne nd place, and	r as stated due to the	d. cause(s)
To th withir To th comp		29b. Signature and title of dertitier	D1 2 []	$\wedge$		29c. License	e number/		29d. Da	ate signed (M	onth, Day	Year)
OFFE	기	2 JOHN CA	100ge M	N		171	6564		7	-1310	18	
Tan		3 NI me and addres, of person who	complete cause of dea	ath (Item 23a	Type, F	ST GATE	80 30	DAM	MC	PULL	all	74407
- Sta		31. Date filed (Month, Day, Year)		's Signature				4 . 4 .				1 - 4
Registra	ar	JUL 0 7 2	2008 Sean	J	1	exis						

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5:13 8005 Mae Baker Anna 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death <u>Washington County Hospital</u> Hagerstown If Under 1 Year | If Under 24 Hrs. Washington Social Security Number 7. Age (In yrs. last birthday) (State or Foreign Date of Birth (Month, Day) 9. Birthplace Country) Year) 1□ M 2XXF Months Days Hours Min Yrs. 215-74-7858 82 Sept.16,1925 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1XXYes 2∐No Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 11 West Baltimore St. Apt. 314 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify. 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 3 Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Durward Grafton Apple Katherine Mills Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catharine E. Burleson - Sister 17103 Reedy Parkway Hagerstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem. Park July 10,2008 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Osborne Affuneraily Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖼 No Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed es 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? only one) 1 Yes 2 No

**Physician** /Medical Examiner

physician and the burial-transit

Hospital or Attending Physician: The law requires that the death certificate be executed

funeral director,

Certification: To

Medical

State

Registrar

After this

ours after death.

neral Director: Af

within 24 hours a

Division of Vital Records, P.O.

Box 68760.

**Physician** 

**Examiner** 

10a, State

Directo

Completed by Funeral

Be

ဥ

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ital Medical Evanirer must be notified at any injury or other traumatic event, Ital Medical Evanirer must be notified at any once.

Baltimore, Maryland 21215-0036

/Medical

Examiner Physician/Medical attending pl for use as t certificate has been signed by the rector, page 2 should be detached Completed by Be

IF FEMALE: 23b. Was decedent pregnant 9 Unknown

27. Manper of Death

1 Watural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day, Year)

				1 🗆 ۱
			26. Place of Death (C	heck o
Hospital:	2 ER/Outpatient	3 □ DOA	Other: 4 Nursing Home	5 🗆

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

fiscritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

determined

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

rummad seem, Mi

and manner stated.

31. Date filed (Month, Day, 0 9 2008 32. Registrar's Signature

DHMH 17 Rev 1/2001

05H-2

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

07

2008

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. To the within 2

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

D24721

29d. Date signed (Month, Day, Year)

June 30, 2008

29b. Signature and title of certifier

08-05420 Dean Carlson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 23559 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day July 14, 2008 2115 hrs al Examiner DEAN MILLS CARLSON 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Annapolis 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Days Months Hours Director MARCH 16,1967 Country/GERMANY 1 X M 2 F 41 215-74-7554 Yrs Usual Residence of Decedent 10d. Inside City Limits ì 10c. City, Town or Location 10b. Count Yes 2 No 28a-f show MARYLAND ANNE ARUNDEL ANNAPOLIS irector 10g. Citizen of What Country' 10e. Street and Number 10f. Zip Code ᡖ 3 WINSLOW COURT 21403 UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 X No Yes Yes 2 No specify: Specify: WHITE If Yes, Give Year Widowed 4 Divorced the Medical Examiner ≥ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+ Pages 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. Baltimore, MD 21215-0036 12 RESTAURANT MANAGER 2 HOSPITALITY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked DEAN MYGATT CARLSON ELKE LOUISA WAHL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) KIRSTIN B. CARLSON (SISTER) 1013 ORANGE ISLE FT.LAUDERDALE, FLORIDA 33315 27 If item 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 X Cremation 3 crematory or other place) Removal from State 07/18/2008 KALAS CREMATORY EDGEWATER, MARYLAND Donation 5 Other Specify: 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 21. Signature of Funeral Service Licenses alas 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037 23a. Parf I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line **Medical** Death a Athersoclerotic cardiovascular disease Immediate Cause (Final disease \_xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. ned by the attending physician and detached for use as the burial - transi Physician/Medical AMENDED 23a,27, perME, g882 8/6/08 TT X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed After this certificate has been a more al director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: examiner? Other 4 DOA Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 Nursing Home 5 1 Yes No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: within 24 hours after wear. To the Funeral Director: Af 1 X Natural Yes 2 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. July 15, 2008 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD 31. Date filed (Month, Day, Year)

JUL 17 2008 32. Pegistrar's Signature Registrar

DHMH 17 Rev 1/2001 **OCME 2006** 

OCME

ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2.0.0.9

		•	For State Of Mar		ertificate of			eg. No.	0 23360
Dhu	sicia	n	1. Decedent's Name (First, Middle, Last)				2. Date of Death	Day Ye	
	edica		ROLAND W. CHANDLER		Ab City Town o	r Location of Death	guly	4c. County of D	
Exa	ımine	er	4a. Facility Name (If not institution, give street and number)  PENINSULA REGIONAL MEDICAL	CENTER		SBURY		WICOMIC	
Fune Direc			5. Social Security Number  222-20-8335  6. Sex 1 \ X M 2 □ F	72 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 4-23-193	9. 36 D	Birthplace (State or Foreign Country) ELAWARE
land	-		Usual Residence of Decedent           10a. State         10b. County         1	0c. City, Town or I	Location				10d. Inside City Limits
Mary a-f sh	Dau .	형	DELAWARE SUSSEX	FRANKFO	ORD				1 □Yes 2√ No
death with the Maryland	St pe no	Funeral Director	10e. Street and Number 30596 ARMORY ROAD		10f. Zip Code 19945	j	11	0g. Citizen of What US	Country?
ING ZIZIS-UU3O  be filed within 72 hours after death with the Marylan ntal Hygiene. dother than "natural", or items 23a or 28a-f show	EXSTRANCE	र्	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Every Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	er in U.S. 13	B. Was Decedent of H If Yes, specify Cuba 1 □Yes 2 ሺ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Ye's or No- Rican, etc.)		American Indian, /hite, etc. WHITE
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within rithan	la la	d lo	Elementary/Secondary (0-12) Coflege (1-4or 5+)		N DEPARTME			FEED MIL	.L
and d be filed ental Hyg red othe	event,	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	•		
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nd 2 s alth an 27 is	n tran		19a. Informant's Name/Relationship (Type. Print) WIFE ELIZABETH M. SHOCKLEY CHAND:		96 ARMORY				
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tificate	S :	edical	-d						
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he Hosp in 24 ho he Fune	in diameter	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of examiner: On the basis of examiner and manner state	xamination and/or	investigation, in my	opinion, death occur	red at the time, d	ate and place, and	due to the cause(s)
To the		Σ	29b. Signature and title of certifier	+ le	29c. Licens	se number	2	9d. Date signed (M	onin, Day, Year)
)			30. Name and address of person who completed cause of dear	th (Item 23a) (Typ	Print)	743		-4-7	00
BA 6			BENJAMIN MEYER MD. 10	O E. CAM	noll ST.	SALISBU	ing Mo	21801	
Reg	State gistra	٠ ا	31. Date filed (Month, Day, Year)  JUL 0 9 2008	s Signature	locale)		,		

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 10:29 P™ Rick Lee Colbert 2008 Ju1v4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days 1**√** M 2□ F Months Hours Min 59 <u>217-</u>52-3733 1948 Ohio Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Edgewater 1 ☐Yes 2 TNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1621 Cambridge Road 21037 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 1968-70 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Communications Shipping Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Smith unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1621 Cambridge Road, Edgewater, Maryland Annette S. Colbert/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 7-10-2008 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Solvice Licon 2973 Solomons Island Rd., Edgewater, MD. 21037 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) cardiomyopathy 3chemic Due to (or as a consequence of): Artery disease atherosclerotic Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

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To the Hospital or Attending Plantin 24 hours after death.
To the Funeral Director. After the completely filled in by the funeral

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Baltimore, Maryland 21215-0036

12 should be filed with and Mental Hygier 7 Is marked other the

permit. Pages 1 and 2 should be Department of Health and Ments Important: If item Z7 Is marked any Injury or other traumatic evonce.

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant 1 ☐Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

renal Cirmosi

24a. Was an 2 No 1 □Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

27. Manner of Death 1 Matural 2 Accident 3 Suicide

4 Homicide

5 Pending investigation 6 Could not be

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number D58510 29d. Date signed (Month, Day, Year) 07/04/08

30. Name and address of person who completed a cause of death (Item 23a) (Type, Print) Steph Olexo

Registrar

31. Date filed (Month, Day, Year)

istrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2008 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician SHAZON 07 DIANA CARBAUGH 2008 /Medical 4a. Facility Name (If not institution, give street and number)
14455 Broadfording Road 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Clear Spring, If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 9 - 9 - 1 9 4 7 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛱 F MD 212-50-8885 60 Director Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show MD Washington Clear Spring 1 ☐ Yes 2√☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14455 Broadfording Road 21722 U.S.A. by Funeral h and Mental Hygiene. 7 is marked other then "natural", or itams treumatic event, it e Medical Examiner ma 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 Tes 2 No 1 Never Married 22 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specity: Specify: white If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry residence Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Ray Eldon Gruber, Sr. Dorothy J. Silvers ပ 19a. Informant's Name/Relationship (Type, Print) husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold Lynn Carbaugh 14455 Broadfording Rd. Clear Spring, MD of Health of item 27 i other t 20c. Location - City or Town, State 722 20a. Method of Disposition 20b. Place of Disposition (Name of July Dat 0, Blairs valley Cem. 1 XBurial 2 □ Cremation 3 □ Removal from State Clear Spring, MD = 5 Department or Important: If any injury or once. 2008 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, P.O.BOX 310 Clear Spring, MD 21722 Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician rult forme glioblastona /Medical Fue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician s the burial Box 68760, Physiclan/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Vear 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 sl autopsy performed? 1 ☐ Yes 2 NO Hospitel or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Sesidence 6 Other (Specify) 2 1 🗌 Yes this 28c. Injury at Work? 27. Manner death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 atural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 - Homicide filled in 24 hours a 29a. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 151043 ar. 30. Name any address of person who completed cause of death (Item 23a) (Type, Print) 511-20 17 WESTERN MJ Itu o en s Tunn 5. CANUSO RO JUL 0 9 31. Date filed (Month. State 2008 Registrar Blesve & Spark

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	State of Maryland / Department of Health and Mental Hygiene  1 - State Recistrar  Certificate of Death  Rec. 2008 2356											23563	
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	/Medi		4a. Facility Name (If not institut.	4b. City, Town,	or Location of	July	4c. County	2008	0.37 2				
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			Washington Adv  5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	If Under 1 Year	lakoma P			Montgo	mery ace (State or Foreign	
	Funeral Director		-	1 M 2 X F		4 Yrs.	Months Days		Min. 8. Date of Birth (Month, Day March 13	Year)	Count	try)	
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	the Maryla 28a-f sho	Director	10e. Street and Number	ince deorge s			10f. Zip Code	Mdelbul	1	10g. Citizen of What Country?			
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Ball	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service	a Luc	lewa	) Hi		li Funera	al Home, Inc. Avenue, Silve	er Spring	. Marv	land 20904	
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		8	shock, or heart failure. List only one cause on each line.									Interval Between Onset and Death	
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J of			27. Manner of Death	28a. Date	of Injury th, Day Year)	28b. Time of Injury	28c. inju	ry at	28d. Describe ho	w injury occurr	ed		
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** P SHIMER DARR 07 14 08 2355 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALLEGANY WMHS-BRADDOCK CAMPUS CUMBERLAND | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Day, Year) | 1/21/1922 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months 1 1 X M 2 □ F PĂ 175-18-8932 86 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State show r 28a-f sh 1 ☐ Yes 2 ☐ No Director PA Somerset Co. Meversdale 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or e 1261 Murray Road 15552 USA "natural", or items 23a death \ Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or itea ury or other traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Minister 12 Church 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Cydney McDonald ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Valentine 1261 Murray Rd., Meyersdale, PA 15552 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or Center Church Ceme. 7/19/2008 Garrett, PA 4 Donation 5 Other (Specify) 22. Name and Address Family Rowe Price Funeral Home, Inc. 21. Signature of Funeral Service L CC0376 325 Main St., Meyersdale, PA Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cerebrovascul Acute disease or condition resulting in death) day /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 □ Ectopic pregnancy for Month 5 Other (specify) ed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 s autopsy performed? Yes 22 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 7

Division or Vital Records, Hospital or Attending Physician: funeral dir After this within 24 hours after death

To the Funeral Director;

completely filled in by the f the

1 Tes 2 No 27. Manner of Death

1X Natural 2 Accident 3 ☐ Suicide 4 Homicide

(Check only

31. Date filed (Month

5 Pending investigation 6 Could not be determined

1 Inpatient 28a. Date of Injury 28b. Time of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 □ Yes 2 □ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certific

JUL 1

7 1

2008

29c. License number DOU 3328U 29d. Date signed (Month, Day, Year)

State

Medical Certification:

8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gupta 625 Kent 32. Registrar's Signature

umberland

Maryland

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			i icasc	State of Ma				•		•			
			1 State	State of Ma		partment of F ertificate of			0000	22566			
			1. Decedent's Name (First, Middle, L.	ast)		erincale or	Dealli	2. Date of Dea	•g. No? () () {	3. Time of Death 4.			
	Physic		Victor 1	200 m.	ad 1	Desac	0001	Month	Day ZO	ar C14			
1	/Medi Examir			ve street and number)	2011	4b. City, Town, o	or Location of Death	0 (	4c. County of Di	5,0,10			
	LAGIIII	**	4a. Facility Name (If not institution of		n RA	1 6 City, Town, o	cider	1	Gam	ett			
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 9. E	Birthplace (State or Foreign Country)			
	Director		111 14 0171	1 <b>2</b> M 2□F	87 Yrs	Width S Says	710313	12-72-		Pennsylvania			
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits			
	Mary f sho	ō	PA Adams I			tlestown			1 ☐ Yes 2 <b>X</b> ☐ No				
	1 the	rec	10e. Street and Number		10f. Zip Code		0g. Citizen of What	Country?					
	th with	ai D	26 Wheaton Driv	е		17	7340		USA				
	within 72 hours after death with the Maryland ane. than "natural", or iteme 23a or 28a-f show ha Madical Examitor i wal be multified at	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 1	3. Was Decedent of H	Hispanic Origin? (Sp	pecify Yes or No-	14. Race - A Black, W	mencan Indian,			
36	or it	by Fu	1 Never Married 2 Married	1 X Yes 2 □ N	o	1 ☐ Yes 2 ☑ No			Specify:	white			
21215-0036	hour tural	d be	3 X Widowed 4 □ Divorced  15. Decedent's E	Year or Dates:	160 De	and add Havel Once		_					
5	in 72	Completed	(Specify only highest gr	ade completed)	(G.	cedent's Usual Occup ve kind of work done o. DO NOT use retired	during most of work	ang	Tob. Kind of Busine	b. Kind of Business/Industry			
212	filed with Hygiene Ather the	mo	Elementary/Secondary (0-12)	College (1-4or 5		eelworker			Steel				
Pu	be filed ntal Hygi od other avent.	Bec	17. Father's Name (First, Middle, Las.	")			18. Mother's Nam	e (First, Middle,	Maiden Sumame)	den Sumame)			
Va Ja	2 should be and Mental is marked o	To	Joseph F. DeGasp	eri			Annetta	Zenoni					
Maryland	2 sho and is m		19a. Informant's Name/Relationship			uling Address (Street D. Box 312			r, City or Town, State 21561	a, Zip Code)			
	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Itam 27 is marked other than "natural", or iteme 23s or 28s-f show other traumatic event. In Medical Examiliar Liver Lives		Charles J. DeGas  20a. Method of Disposition	per 1/ son		position (Name of		Date .		T Chair			
Baltimore,	Pages nent of H nnt: if Itu		1 X Burial 2 ☐ Cremation 3		cemetery, c	rematory or other plac	CB)		20c. Location - City				
Ē	- 분운증		4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service;Lige		Mononga	hela Cem.	July 12	2008	Monongahe.	la, PA			
Ba	permit. Depart Import any inj		In July	Olimar	)	22. Name and Addre				s, P.A. le, MD 21536			
	# A		23a. Part1. Enter the disease, or con	plications that caused	the death. Do not					Approximate			
	Physician		shock, or feart ailure. List only Immediate Causer Final	one cause on each lin	o.					Interval Between Onset and Death			
	/Medical		disease or condition resulting in death)			years							
35.	eath certificate be executed x attending physician and for use as the burial-transit of		Sequentially list conditions	b.									
		iner	Sequentially list conditions, any leading the cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):									
		Examiner	that initiated events resulting in death) Last	consequence of):									
760,	be e) iician buria	caiE		Due 10 (01 as a	consequence or).								
687	ficate phys			_ d									
Box	s certi	N/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	23d. Date of	delivery							
	death e atte	Icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at		3 □Ectopic pregnancy 5 □ Other (specify) _	/	Month	Month Day Year				
P.0	at the de by the	Physician/Med	9 🗆 Unknown	9□ Unknown									
	The law requires that the death certifica tie has been signed by the attending phy page 2 should be detached for use as th		Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause giv	en in Part I.			to the cause of death?			
ord	w require been sij should b	ted	Trial 4	DVII ROI	IVO			1 🗆 Yı	es 2 No 3	Probably 4 Daknown			
Vital Records,	elaw hasb e2sl	Completed by	Caratomi	10 party	7			24a. Was a autops	y prior	autopsy findings available to completion of cause of			
<u>a</u>			Av terio so	LEYUTIY	- COYON	argarte	ry disea	yes perform		'es 2□ No			
		o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:		ingt 3 DOA Oth	000	h (Check only on		19555701)			
o	Physer this eral di	n: To	27. Manner of Death	1 Inpatier 28a. Date of Injur	y 28b. Time	of 28c. Injur	4 🗀 Nursing no	ome 5 Reside	once Other (S ow injury occurred	pecify) LIV; NG			
Division	Attending I death. ctor: After y the funer	Certification;	Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injur		k? Yes 2 □No		The injury occurred				
Vis	er de er de racto	tific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Reconstruction of the building, etc. (Specify) 28f. Location (Street and Number or Reconstruction of the building).										
	itai o irs aft rai Di led in												
	Hospital or Attending 14 hours after death. Funeral Diractor: After tely filled in by the fune	Icai	(Orack Oray Z   Medical Exa	nysician: To the best of miner: On the basis of	examination and/or	ath occurred at the tir investigation, in my o	me, date and place, pinion, death occur	and due to the cred at the time, d	ause(s) and manner ate and place, and c	as stated. If the cause(s)			
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medicai	one) 29b. Signature and title of certifier	and manner sta	led.	29c. Licens			9d, Date signed (Mo				
	F ≥ F 8	6	1 D O A	D110	200	14:	1015	1 7	12/20	06			
		D	Name and address of person who	completed auxe of de	ath (Item 23a) (Typ	e, Print)	rue ( > )	0	6) 10	-0			
		VA	Paul Daniel	M1/10	DO 60	1 Walt	Cheres	Dv C	axland	MD 57235			
, ks	Sta		31. Date filed (Month, Day, Year)	St. of	r's Signature	1 10							
	Registr	ar	JUL 15	2008	as B								

3altimore, Maryland 21215-0036

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, physician the use as signed by the at d be detached for page 2 certificate To the Hospital or Attending Physician:

within 24 hours To the Funeral

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 2008 Ann Marie Driscoll 11:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2570 Riva Road, Apt. 7C Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1□M 2MF Hours New York Yrs 109-28-7129 71 August 4,1936 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 2570 Riva Road, Apt. 70 21401 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 3 Administrative Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maurice Driscoll Evelyn Wolder ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Driscoll / Brother 1110 D. Street, S.E. Washington, D.C. 20003 Department of Healt, Important; If Item 7- any injury 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【X Cremation 3 ☐Removal from State 7-4-2008 Edgewater, Maryland Kalas Crematory 5 ☐ Other (Specify 4 □ Donation 21. Signature 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD. 21037 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate ause (Final dis or condition resulting in death) Uncontrolled Hypertension Due to (or as a consequence of) Arrhythmia Sequentially list conditions, if any, leading to immediate cause. Enter the dentity Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypokalemia 1 | Yes 2 No 3 | Probably 4 | Unknown Completed Hypothyroidism 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA nours after death.

neral Director; After this filled in by the funeral di 27. Manner of Death 1- Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🗌 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0065267 July 03, 2008 30. Name and addres of person who completed cause f death (Item 23a) (Type, Print) Olubukola Tokunbo Amudipe, 2629 Riva Road, Annapolis, Maryland 21401 31. Date filed (Month, Day, Year) Registrar's Signature JUL 0 7 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) July **Physician** 2008 7:05 Рм Berenice M. DiVenuti /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Howard Columbia Vantage House If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year **Funeral** Days Hours Months Min. 1 □ M 2 K F 03-12-1907 Director 227 80 9838 101 Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Director Columbia MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21044 United States 5400 Vantage Point Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Marks Mary Lucis ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Eberhard/Daughter 9214 May Day Court Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Strain 2 ☐ Cremation 3 ☐ Removal from State Columbia Mem. Park Clarksville, MD 4 ☐ Donation 5 ☐ Other (Specify) 7-14-2008 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🛣 No Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy

**Physician** /Medical Examiner

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

s 1 and 2 should be filed v f Health and Mental Hygie Item 27 is marked other t other traumatic event, t

permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr

death certificate be executed the burial-tran attending physician use as jo detached ed by signe be c page 2 certificate Physician: this s after death.
I Director: After this of in by the funeral d

Be

Certification: To

Medical

Division or Vital Records, P.O. Box 68760,

performed? 2 **N**No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

5. was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 ☐ Yes <b>2</b> ₹7 No	Hospital: 1   Inpatient 2	]ER/Outpatient 3 ☐ DOA	Other: 4X Nursing H	ome 5 Residence						
7. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c	c. Injury at Work?	28d. Describe how inju						

2 investigation 2 Accident 6 Could not be 3 Suicide determined 4 ☐ Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cortifler 29c. License number 29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

July 8, 2008

6 ☐Other (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE

State

To the Hospital within 24 hours a To the Funeral I

or Attending

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUL 0 9 2008

Registrar

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

as the burial-transi

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trar

Division or Vital Records, P.O. Box 68760,

an al	IMOGENE ROBINSON	EUGENE	JULY.	4, 2008 6:58AM								
er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location		4c. County of Death								
- 5-	ST. Thomas moore Nursing			Prince & coye's								
	5. Social Security Number  5. The security Number of Security Number o											
	10a. State 10b. County 10c. City	10d. Inside City Limits										
tor	MD. MONTGOMERY SILVER SPRING											
<b>Funeral Director</b>	10e. Street and Number 10f. Zip Code 10g. Citizen of What Count											
al D	2002 FOREST DALE DR.	20903		U.S.A.								
ner	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?		rigin? (Specify Yes or No-	14. Race - American Indian, Black, White, etc.								
/ Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	Specify:										
d b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	BLACK										
lete	15. Decedent's Education (Specify only highest grade completed)	b. Kind of Business/Industry										
Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	PROFESSOR		EDUCATION								
Be C	17. Father's Name (First, Middle, Last)		er's Name (First, Middle, Mai									
To B	KENNETH GARNES			UNK.								
_	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Numb	per or Rural Route Number, C	ity or Town, State, Zip Code)								
	EILEEN M. EDWARDS/FRIEND	2002 FOREST DALE	DR., SILVER SI	PRING, MD. 20903								
	20a. Method of Disposition 1 ☐ Burial 2 ဩTCremation 3 ☐ Removal from State	Place of Disposition (Name of cemetery, crematory or other place)		c. Location - City or Town, State								
		AMBERS CREMATORY	7-9-2008 I	RIVERDALE, MD.								
	21. Signature of Funeral Service Livensee	22. Name and Address of Facil CHAMBERS FUNE		FMATORIIM P A								
		0091  5801 CLEVELANI	D AVE., RIVERI	DALE, MD. 20737								
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Organization Countries of Part 1.											
	Immediate Cause (Final disease or condition a Size of the water and Death 2 works											
	resulting in death)  Due to (or as a consequence of the consequence of	uence of):	n t	DUE								
_	Sequentially list conditions, b.	mares de	1 John									
Examiner	Sequentially list conditions, if any, leading to finine list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):											
Exar	that initiated events resulting in death) Last	juence of):	n Noor									
call	d											
ysician/Medical												
an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Feta	ancy al death 3 □Ectopic pregnancy		23d. Date of delivery								
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Phy	Part II. Other significant conditions contributing to death but not rest	sulting in the underlying cause given in Part	I 23e Did tobar	co use contribute to the cause of death?								
by	Vascular Dementia	uning in the underlying educe given in Fact	1 ☐ Yes	2 No 3 Probably 4 Unknown								
etec	THE SECOND SECOND STATE OF THE SECOND		_									
Completed by			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?								
	OF Wassessels and in the second secon		performe 1□ Yes 2 🗹	No 1 ☐ Yes 2 ☐ No								
) Be	25. Was case referred to medical examiner?  11	O4h - ···	e of Death (Check only one)									
: To	27. Manner of Death 28a. Date of Injury	28b. Time of 28c. Injury at	lursing Home 5 Residence 28d. Describe how									
ation	1 □ Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	h 1/ 11-24 15-11 65	Tho Bullat	Nousing Kode								
ifica	3 Suicide 6 Could not be 28e. Place of injury - At ho	ome, farm, street, factory, office	28f. Location (Stree	et and Number of Rural Route Number,								
Cert	4 Homicide determined building, etc. (Specify)  City or Town, State Tong Count for Specify County Home											
Medical Certification:	29a. Certifier (Check only one)  One)  1 □ Certifying Physician: To the best of my kno 2 □ Medical Examiner: On the basis of examina and manner stated.											
Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month, Day, Year)								
	Bullenlevore	Un D0189	52 T	01852								
	30. Name and address of person who completed cause of death (Item Paul A. DEVOREM) 47	n 23a) (Type, Print) Los Quecustive	Rd Hyai	101852 TSU: 11e Mb 20181								
ite	31. Date filed (Month, Day, Year) 32. Fegistrar's Signal	the Speaks	<b>,</b>									
ar	JUL 0.8 2008 Blown	V. Jallan										

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05116 State of Maryland / Department of Health and Mental Hygiene John Eubank, Jr. 2008 23570 Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Day Month Day 3, 2008 1650 hrs Medical Examiner John Langford Eubank, Sr 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hospital Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Social Security Number 077 - 30 - 3650 Funeral oreign Months Day Hours Min Director DC July 27. 192 80 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No Gaithersburg or 28a-f show Maryland Montgomery ms 23a or 28a-f sho be notified at once. with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 51 Port Side Court 20877 United States 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 2 X Married death 1 Never Married 1 X Yes White Yes 2 X No specify: Specify. If Yes, Give Year 1948-1949 imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after Divorced "natural", ۵ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than ' atic event, the Medical 12 Contractor Remodeling Health and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Gordon Eubank Emma Gladys VanHorn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print ) 13119 Lake Geneva Way, Germantown, MD 20874 Michael G. Vallarino (Son) it of Health 2 20c. Location - City or Town, State Date 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, Itimore, Metropolitan Crematory July 9, Alexandria, Virginia 2<u>008</u> Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Utens DeVol Funeral Home, MD 20877 10 E. Deer P<u>ark Drive, Gaithersburg</u>, 23a. Part I. Enter the direase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail be. List in or a list on each line. Approximate Interval Between Onset and Physician Death /Medical a. Multiple Injuries Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical ned by the attending physician detached for use as the burial UNPENDED #500ETNF,7-15-08,HWW,McCo To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year Day 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live hirth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 ✔ No 3 Probably 4 Unknown signed l be deta ş Completed 24a. Was an 24b. Were autopsy findings available peen prior to completion of cause of autopsy death? has l performed? ✓ Yes 2 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital funeral director, Be Other; Hospital: 1 ✓ Inpatient 2 Nursing Home 5 Residence 6 Other DOA ER/Outpatient 3 After this 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month Day,Year) Jul 3, 2008 28b. Time of Injury 27. Manner of Death Driver auto auto collision Certification: 1312 hrs Yes 2 V No Natural Pending Director: d in by the f hours after death 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Midcounty Hwy and Woodfield Rd, Gaithersburg, MD Suicide within 24 hours at To the Funeral D completely filled determined (Specify) Major Road / Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 4, 2008 O.C.M.E. Our onte nell 30. Name and a dress of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Margarita Korell MD. strar's Signature 31. Date filed (Month Day, Year) 32. Rd

Registra

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		1	1- For State Certificate of Death								,,,	Reg. No. 2008 235					
Med	Physicia ical Examir	n/	Registrar  1. Decedent's Name (First, Middle,Last) Richard Scott Findley									2. Date of Death Month Day Year June 27, 2008				Time of Dea 1230 hrs	1
1			4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of D  Laurel Regional Hospital									P	4c. County of Death Prince George's				
	Funeral Director		5. Social Security Number 218-96-9524	6. Sex	7. Age (In yrs. la	st birthday	Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	-			Foreign	lace (State o try) Mory 1	
	ŕ		Usual Residence of Decedent 10a. State 10b. Count		10c. City,	10c. City, Town or Location										0d. Inside Ci	ty Limits
	land f show a	ō	Maryland Carrol	Ne	New Windsor					_	10g. Citizen of What Count				Yes 2	∑ No	
	the Mary a or 28a- tified at	Director	10e. Street and Number 1205 Jo Apter Pla		10f. Zip Code 21776					United States				,			
•	Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	uneral	11. Marital Status 1 Never Married 2 X	ecedent Ever in U. Forces? 2 X No	orces? If Yes			S Decedent of Hispanic Origin? (Specify Yes of es, specify Cuban, Mexican, Puerto Rican, etc.  Yes 2 No specify:				White, etc.				ick,	
	urs after tural", c	d by F	3 Widowed 4 15. Decedent's Education (S	ear ade completed)	16a. Dec	edent'	s Usual (	Occupation	on (Give I	kind of wo	work done 16b. Kind of Business/tnd						
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	MD 21215-0036 d 2 should be filed within 7 Ith and Mental Hygiene. n 27 is marked other than numatic event, the Medica	Be Con	17. Father's Name (First, Midd John Findley	le, Last)					I	elore	es Cab						
	1D 21, 2 should be and Men 27 is mar matic eve	10	19a. Informant's Name/Relation Kelly M. Findley									ral Route N dsor, N				Zip Code)	
	ore, Nges I and of Health If item		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  Lakemont Memorial Gardens 7/3/2008  Davidsonville									lami					
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1	'Medical caminer	'n	Immediate Cause (Final diseasor condition resulting in death	ase a. Multiple I	njuries s a consequence d	of):		_								Dea	ath
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	760, ficate be execute g physician and the burial - tran	- 1	UNPENDED	d AMENDE	D												
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	sician/Medica	IF FEMALE: 23b. Was decedent pregnant past 12 months?	n the 1 Liv	s, outcome of preg e birth egnant at time of d	2		tal death ner (Spe	3 [ cify)	Ectop	ic pregnar	ncy		3d. Date o	of delivery D	ay	Year
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The law required to medical sexaminer?  25. Was case referred to medical examiners.  26. Place of the law required to medical examiners.  26. Place of the law required to medical examiners.  27. Manner of Death or Month Day Year.  28a. Date of Injury.  28b. Time of Injury.  28c. Injury.  28c. Injury.  28c. Injury.  28c. Place of Injury.  28d. Day Ordiffer.  28d. Place of Injury.  28d. Day Ordiffer.  28d. Day Ordiffer.  28d. Day Ordiffer.  28d. Place of Injury.  28d. Time of Injury.  28d. Injury.  28d. Place of Injury.  28d. Day Ordiffer.  28d. Place of Injury.  28d. Day Ordiffer.  28d. Place of Injury.  28d. Day Ordiffer.  28d. Day Ordifer.  2									NO I	tc. 28f. Location (Street and Number or Rural Route Number, C							
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27. Manner of Death    1									occurred a	ed at the time, date and place, and due to the cau  29d. Date signed (Month, D				e cause(s)	r)		
	25	Σ	29b. Signature and title of co	runer				25	O.C.		,			ine 28,		, Duy, 1 ca	
	<b>O</b> GME		30. Name and address of pe Mary G. Ripple MD		cause of death (Ite		11	1 Penr	Street	t, Baltir	nore, M	D 21201					
	-	tate	31. Date filed (Mort, , Qay, Y	007 2008 32	. Registrar's Signa	iture/	De	Car.	,								

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Fletcher 6:30 AM 04 Macon 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Princess Anne If Under 1 Year | If Under 24 Hrs. Somerset Manor Manokin 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 1 M 2 F Days Hours 68 Yrs. Director 212-40-8641 10/19/1930 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Madical Examiner must be notified at 1 Yes 2 No Director Worcester Pocomoke 10e. Street and Number 10a. Citizen of What Country? 10f. Zip Code ö 238 Street 21851 aurel + Funeral Race - American Indian, Bfack, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) , or Items 11. Marital Status 1 Yes 2 No ff Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ 3 Widowed 4 □ Divorced Blac 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygienn Important: if Itam 27 is marked other the eny injury or other traumatic event, Itam 2006. cean 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Savage Burnadine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) argis/son Street Pocomike City MD 21851 600 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Pocomoke, MD 13/08 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Funeral Swice Licensee 21. Signaturi 917 W. Isabella St. Bennie Smith Funcial Home Salisbury MO 31201 Part. Enter the disease, or complications that caused in shock, or heart failure. Ust only one cause on each fine. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 | Fetaf death in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 Probably 4 Unknown 1 Tyes 2 KNo 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed? Division of Vital 1 Yes 2 No 25. Was case referred to medi 1 examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 'Mursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 KNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After s after dea. ral Director: Aft 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide fo the within 24 hour.
The Funeral D' 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D29505 Dellard, Ku Coreno M. Name and odress of person who completed cause of death (Item 23a) (Type, Print) BA2 GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801

Date filed (Month, Day, Year)

32. Begistrar's Signature 31. Date filed (Month, Day, Year) State 0 9 2008

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Maryland		artment of tificate of		nd Ment	al Hygier	ZUUC	23573
			Decedent's Name (First, Middle, Last,						ate of Death		3. Time of Death
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	/Medio Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of			4c. County of Deat	
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	Funeral Director		5. Social Security Number 6. Sec 232-26-1241	7. Age (In yrs. It	ast birthday) Yrs.	If Under 1 Year Months Days			ate of Birth Nonth, Day, Ye y 26	ar) Co	hplace (State or Foreign untry)
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21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other then "natural", or iteme 23a or 28e-f ehow other traumatic event, the Medical Examinal matter nutilised at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		f Yes, specify Cu 1 ☐ Yes 2 ☐ No		Puerto Rican	, etc.)	Specify: wh	
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Maryland	and 2 sho salth and n 27 ie m		19a. Informant's Name/Relationship (Ty Charlotte Schul							ty or Town, State, 2 CEMETE,	
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sio	Attending r death. •ctor: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				]Yes 2□N				
Division of	after of Direct Direct of In Dy	Certification;	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office	9	28f. L	ocation (Stree City or Town, S	t and Number or Ri tate)	ural Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After cumpletely filled in by the funer	Medical C	25s Cartifier (Check only one) 12 Cartifying Phy 2 Medical Exami	icium: To the best of my know ner: On the basis of examinat and manner stated.	wladge death ion and/or in	vestigation, in my	tirns, date and opinion, death	place and d h occurred at	ue to the eaun the time, date	e(c) and thanner at and place, and due	etated, e to the cause(s)
	To the Co the	Me	29b. Signature and title of certifier	. 10-		29c. Licer	nse number		29d.	Date signed (Mont	h, Day, Year)
	WIL		John W. M	Adleton mo		Do	5443	3	9	14/7 11.	8
	W 4		30 Name and address of person who co	empleted cause of death (Item	23a) (Type,					11 600	_
	,		John W. middle	len 3337 Vie	fory :	Street	man	cheste	or M	D 2110	2-
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	,			7		
	Registr	ar	JUL 0 8	2008 Kleen	K 1	book					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item State Registrar #7, perF. Home, 7/7/08, B.A. 23574 Certificate of Deathword 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month -**Physician** Year 08 0128 A-M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ATLANTIC GEW. fessil AL BERLAN WORCESTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6/18/1922 Birthplace (State or Foreign Country) **Funeral** Months Hours Min 1 M 2 X F Days <del>85</del>-86 214-18-6452 MD **Director** Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, The Middon Examination must be invitined at Director 1 ☐ Yes 2X No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50 Quarterstaff Place 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \_\_Yes \_2X\_\_No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: þ Specify: 3 ☐Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fill the and Mental H Jesse Sears Mary V. Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau George D. Fiedler / son 50 Quarterstaff Place Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Pages 1 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 7/7/2008 Cape Henloph Crem. Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Kicensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ISCHEMIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Exami burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FNCE 1 ☐ Yes 2 ☐ X 6 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **X**√0 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation by the f after death 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide filled in † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier D0059975 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BROAD ST SMITE DOI BERLIN, MD 21811 BA 6 1 HUAN 31. Date filed (Month, Day, Year)

JUL 0 7 2008 Registrar's Signature State Registrar

			For	State of	of Marylan		artment of H		Mental Hy	giene		
		_	1 - State Registrar			Cei	tificate of	Death		Reg. No.	2008	23575
	Physici	an	1. Decedent's Name (First, Middle		T P P P				2. Date of Dea	Day	2008 2008	3. Time of Beath/
	/Medic	cal	DOROTI  4a. Facility Name (If not institution				4h City Town o	r Location of Deat		28,	2008 County of Death	4:35 PM
A	Examin	ner	Cherry La			nter		irel			RINCE G	SEORGES
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.				8. Date of Birt	h	9. Birthp	lace (State or Foreign
	Director		220-14-8703	1 □ M 2 <b>½</b> F	85	Yrs.	Worturs Days	Hours Will.	July 2	3,19	922 Ma	ryland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				1	0d. Inside City Limits
	Maryl f sho	ō	MD Pr.	Geo		La	urel					1 XYes 2 No
	r 28a	Director	10e. Street and Number				10f. Zip Code	<u> </u>		10g. Citiz	en of What Cour	ntry?
	th wit		803 West S	treet			2	20707		Ţ	J.S.A.	
	be filed within 72 hours after death with the Maryland that Hyglene.  dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	Armed F		.S. 13.	Was Decedent of H	lispanic Origin? (9 an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	- 1	<ol> <li>Race - Americ Black, White,</li> </ol>	
20	rs afte	by Fi	1 ☐ Never Married 2 ☐ Marr  \$☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes If Yes, G Year or D	2[XNo live Dates:		1 □ Yes 2 No	Specify:			Specify: B1	ack
12-0036	2 hour		15. Deceden	t's Education		16a. Dece	dent's Usual Occup	ation	-	16b. Kir	d of Business/Inc	dustry
<u>က</u>	hin 7% e. an "na Medi	Completed	(Specify only higher Elementary/Secondary (0-12)	<del></del>	) (1-4or 5+)	(Give life.	kind of work done DO NOT use retire	during most of wo d)	orking			
7	er the	Son	3rd			Do	omestic				Home	
and	be file	Be	17. Father's Name (First, Middle,	Last)					me (First, Middle, Powell		Surname)	
>	12 should be filed v n and Mental Hygie Is marked other t raumatic event, th	မ	UNK	his (Tors Dales)		405 14-10	Add (C44				T 01-1- T-	Code) 20721
Ma	permit. Pages 1 and 2 should by Department of Health and Mente Important: If Item 27 Is marked any Injury or other traumatic evonce.		19a. Informant's Name/Relations Dorothy J. P		n (Daud	hter)	1001 Address (Street	and Number of A Arbor P	ark Pl,	er, City or Mit	chellvi	111e,MD
ā,	f Heal		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of matory or other pla	1	Date		cation - City or To	
saitimore,	Pages nent of l ant: If ite	-	1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		i State I		Church		/3/08	La	urel, M	1D
alt	rmit. porta porta y Inju		21. Signature of Funeral Service	Loonse	ulla.	/ 22	2. Name and Addre	ss of Facility S				OME P A
<u>n</u>	9 2 E 5		CHANGE!	1. Due	ureu						kville,	MD 20850
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat each line.	th. Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)		neumon:							Onset and Death
	/Medical Examiner		, totaling in dealiny		(or as a conseq	. ,						
		ē.	Sequentially list conditions, if any, leading to immediate	b. Re Due to	espiral o (or as a conseq	uence of):	Failure					
	outed id ransit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c. G	eneral	Debi	lity					
Š	icate be executed physician and s the burial-transit		resulting in death) Last	Due to	o (or as a conseq	quence of):	_					
8/60	cate b	dical		d								
χ Q	certificate iding phys ise as the	/Me	IF FEMALE:	23c If yes, or	utcome pf pregna	ancv					04 Data et delle	
X P P	atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	birth 2 Feta gnant at time of o	aldeath 3[	Ectopic pregnanc Other (specify)	У		2	3d. Date of delive Month	ery Day Year
j.	the d	Physician/Me	1 ☐ Yes 2X No 9 ☐ Unknown	9□Unki			(47)					
ιζ.	w requires that the death certific been signed by the attending I should be detached for use as	by PI	Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	nderlying cause giv	ren in Part I.	23e. Did t	obacco u	se contribute to the	he cause of death?
Kecoras,	equire en sig ould b	edt	Dementi	a					1 🗆 '	Yes 2	<b>X</b> No 3 ☐ Prot	pably 4 □Unknown
ပ္ပ	2 38 A	Completed	Failure	to Thr	ive				24a. Was	osy	24b. Were auto	opsy findings available impletion of cause of
	ate pag	Co							perfo 1⊟ Yes	rmed? <b>2€∑X</b> No	death? 1 □ Yes	2 No
VItal	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hoenital:			ot 3 DOA Oth	or.	eath (Check only c			
ō	Phys this ral dii	<u>ا</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time o	11 30 DOX	4 LANUTSING	Home 5 ☐ Resi			(y)
0	Attending F r death. ector: After by the funera	tion	Natural 5 ☐ Pendin 2 ☐ Accident investi	q (Moi	nth, Day Year)	Injury	Wo	rk? Yes 2 ∐ No			, 0004.104	
UIVISION	Attendi	ifica	3 Suicide 6 Could 4 Homicide determ	ined 28e. Plac	ce of injury - At he	ome, farm, str	eet, factory, office		28f. Location (	Street and	d Number or Rura	al Route Number,
5	pital or Al ours after of leral Directilled in by	Certification:	T C TIONIOGO	Duik	unig, etc. (Specia	·y/			City of Tol	wii, State		
	dospi 4 hour Funer ely fill	edical	(Check only 2 Medical	ng Physician: To the Examiner: On the	basis of examina							
	To the Hospital or Attene within 24 hours after death To the Funeral Director; completely filled in by the	Medi	one) 29b. Signature and title of certifie		nner stated.		29c. Licens	se number		29d, Date	e signed (Month,	Dav. Year)
	F.≱ F. 8		· M	an				0045217	'	7	/1/08	
	5		30. Name and address of erson	who completed cau	use of death (Iter	m 23a) (Type.	Print)					
			Adebowalf A		i.D. 6	201 G	reenbel	t Road,	Colle	ge P	ark, M	D 20740
U	Sta		31. Date filed (Month, Day, Year)	7 2008 32.	Registrar's Sign	ature	Angelt 1					

		1 - State Registrar	-	epartment of F Certificate of I		R	eg. No. 2 ()	08.	23576	
Physi		1. Decedent's Name (First, Middle, Last)  Terry Wallace G	riffith			2. Date of Deat Month <b>June</b>	Day	Year 2008	3. Time of Death 12:30 pM	
/Med Exam		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of			
1		14804 Claude Lane			Silver Sprin			Montg		
Funera Directo		227-60-0100 1 M 2 ☐ F	(In yrs. last birth	rs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 7	; Year)	Counti	nce (State or Foreign y) nesota	
and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location	-			10	d. Inside City Limits	
Maryl -f sho	호	Maryland Montgomery		Ç.	llver Spring				1 ☐ Yes 2 ☑ No	
r 28a	Director	10e. Street and Number		10f. Zip Code	TVCI bpling		0g. Citizen of W	hat Count	y?	
th with		14804 Claude Lane			20905			U.S.	Α.	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventhal Thistochillised at	Funeral	11. Marital Status  12. Was Decedent E Armed Forces?  1 ▼ Never Married 2 ☐ Married  12. Was Decedent E Armed Forces?  1 ▼ S ☐ Was Decedent E Armed Forces?		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black	- America k, White, et		
21215-0036 d within 72 hours aff giene. er than "natural", or she Medical Every	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1					Specify:		White	
15- n 72 h	Completed	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usual Occup 'Give kind of work done ( life. DO NOT use retired	during most of work	ing	16b. Kind of Bus	siness/Indu	istry	
vithin vithin the Me	omp	Elementary/Secondary (0-12) College (1-4or 5+	-)	lectronic Hard		ner	Cable	& Wir	eless	
d Filed of Hygi	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name		Maiden Surname	9)		
/lan uld be Wental riked o	70 E	Terry Delmer Griffi	th			Ina Jo	Pace			
faryla 2 should I and Men is marke		19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Address (Street	and Number or Rur	al Route Numbe	Number, City or Town, State, Zip Code)			
and and and and an arthur and arthur		Anne Griffith Tew - Sister		Groome Road,		-				
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hymportant: If item 27 is marked othmy Injury or other traumatic event any Injury or other traumatic event		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State	20b. Place of I cemetery	Disposition (Name of crematory or other place	ce)	Date	20c. Location - (	City or Tov	n, State	
Itim it. Pa rtmer rtant: njury	λ	4 Donation 5 Other (Specify)	Ft. Lin	ncoln Cremator		8/2008	Brentwood	i, Mar	yland	
Baltil permit. P Departm Importal any Inju	ouce.	21. Sign flure of Funer & Service Ligenses		22. Name and Addre Hines-Rinald 11800 New Ha	li Funeral I	Home, Inc. enue, Silv	er Spring	, Mary	land 20904	
Physicia /Medica Examine	il r	resulting in death)  Due to (or as a b.	the death. Do note.  The consequence of a consequence of a consequence of	noma f):	ng, such as cardiac	or respiratory arr	est,		Approximate interval Between Onset and Death 6 months	
ds, P.O. Box 68760, ires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	2 🗌 Fetal death	3 ☐ Ectopic pregnanc	у		23d. Date Mor	e of deliver	y Day Year	
P.C hat the		9 ☐ Unknown  Part II. Other significant conditions contributing to death bu	t not resulting in	the underlying cause giv	en in Part I	23e. Did to	bacco use contr	ibute to the	cause of death?	
rds, quires t an signe	d by		t not roodking in	the didenying eaded giv	on in runt.				ıbly 4 ☐ Unknown	
on of Vital Records, P.O. Box ding Physician: The law requires that the death cer h. After this certificate has been signed by the attendin funeral director, page 2 should be detached for use	Completed					24a. Was a autop: perfor 1 ∐Yes	med? d 2 X No 1		sy findings available pletion of cause of 2 □ No	
Vit sicia s centi irecto	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatier	-t 0. TER/Out	patient 3 DOA Oth	er:			10		
ding After	tion: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ome 5 Resid 28d. Describe h			)				
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification: To	2 □ Suiside 6 □ Could not be		m, street, factory, office	Yes 2 □ No	28f. Location (S City or Tow		er or Rural	Route Number,	
the Hospital hin 24 hours a the Funeral I	Medical (	29a. Certifier (Check only one)  1  Certifying Physician: To the best of the deciral Examiner: On the basis of and manner sta	examination and							
To the I within 2 To the I сощрей	Me	29b. Signature and title of certifier	3 -	29c. Licens		2	29d. Date signed		_	
10		30. Name and address of person who completed cause of de	Herr /kl	Type, Print)	D22775		July	3, 200	8	
		Frederick G. Barr, M.D., 5454 Wi			1300, Chevy	Chase, Ma	aryland 20	815		
S Regis	state			Specific						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 200 2. Date of Death 1. Decedent's Name (First, Middle, Last) GOLDBERG Grace July 5, 2ŏb8 8:55 A. M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgomery Bethesda <u>Suburban Hospital</u> If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month) Days | Hours | Min. | April 16, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number Year) 1929 New York 1 □ M 2 🛛 F **7**9 Months 102-20-5682 Usual Residence of Decedent 10a. State 10b County 10c. City. Town or Location Silver Spring 10d. Inside City Limits MD Montgomery 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 20902 11616 Lovejoy St. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 □Yes 2 □NO Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Math & Computer Teacher 18. Mother's Name (First, Middle, Maiden Surname)
Claira Dicker 17. Father's Name (First, Middle, Last) Reinhardt Benjamin 19a. Informant's Name/Relationship (Type. Print) Nancv Goldberg / daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14242 Long Green Dr., Silver Spring, MD 20906 July 7, 2008 Rockville, MD 20b. Place of Disposition (Name of 20a. Method of Disposition Menoran Gardens 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Fun-ral Service Licensee 20012 Washington, DC 254 Carroll St., NW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) elemone W weeks Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □ Yes 2 **N**0 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28c. 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Examiner P.O. Box 68760 Rec6rds. of Vital Division

attending physician and for use as the burial-transi signed by the a d be detached for icate has been si , page 2 should b this certificate To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Iro Modical Examiner must be retified at once.

**Physician** 

/Medical

Examine

Physician/Medical

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Completed

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Certification: To

Medical

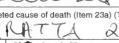
Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifie

29a. Certifier

ME T



and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401

31. Date filed (Month, Day, Year)

0 8 2008

32 Registrar's Signature

			State Registrar	State of Maryland / Dep.  Ce	rtificate of Death	Re	g. No. 2008	23578
	Physicia		1. Decedent's Name (First, Middle, Last)  Milton	GORDON		July 6,		3. Time of Death 10:14P M
	/Medic Examin		4a. Facility Name (If not institution, give str Suburban Hospita		4b. City, Town, or Location of Deat Bethesda	h	4c. County of Death Montgomer	·y
	Funeral Director		Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day,		place (State or Foreign ntry)
	Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County MD Montgomery	10c. City, Town or Lo Bethesd				0d. Inside City Limits 1 □ Yes 2 □ XNo
	th with the Marylan 23a or 28a-f show	Funeral Director	10e. Street and Number 5225 Pooks Hill Rd	. #229S	10f. Zip Code 20814	10	og. Citizen of What Cour	itry?
9036	urs after dea al", or items Examiner m	by	11. Marital Status 12 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	1 AYes 2 No ATTILY If Yes, Give Year or Dates: Korean	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 □Yes 2 ☑ No Specify:		14. Race - Americ Black, White, Specify: Wh	ite
1215-(	ithin 72 h ne. han "natu	Be Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion 16a. Dece completed) (Give life.	Ident's Usual Occupation  kind of work done during most of wol  DO NOT use retired)	rking	Consulti	
nd 21	e filed wall Hygie	Be Co	17. Father's Name (First, Middle, Last)			me (First, Middle, M		19
ıryla	should b and Ment s marked	To	Isadore Go			Pisner	City or Town, State, Zig	1.Godel "
e, Ma	f and 2 s Health a sm 27 is ther trau		Sondra Gordon / Spo 20a. Method of Disposition		ng Address (Street and Number or P Pooks Hill Rd., #			
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical once.		1 M Burial 2 ☐ Cremation 3 ☐ Ret 4 ☐ Donation 5 ☐ Other   Specify)  21. Signature of Fulleral Signature of Fu	0 / 12	osition (Name of matory or other place) morial Garden Jul 2. Name and Address of Facility	rchinsky	Hebrew Fun	eral Home
B	permit. Depart Import any Inj		Muhret &	12mm 12	54 Carroll St., N	w, wasnir	igion, be 2	0012
4	Physician /Medical		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Due to (or all a consequence of);	ter the mode or dying, such as cardial		THE _	Approximate Interval Between Onset and Death
Ω	Examiner	J.	Sequentially list conditions, b.	Due to for as a consequence of):	RENAL	Paul	V4P	
2 - Q	icate be executed physiclan and the burlal-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last	Due to (or as a consequence of):	2 Mellite	5		
7/CC	ficate be physicl s the bu	ledical	d.					
0. Box	attendin for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	ery Day Year
7/6 rds, P.	requires that the d	ed by Ph	Part II. Other significant conditions contr	ibuting to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
いけらい Vital Record	he lav ate has pege 2 sl	Completed by				24a. Was ar autopsy perform 1 ∐Yes	y prior to co	opsy findings available impletion of cause of
	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?  1 Yes 2 No	spital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	- C Other:	ath (Check only one	nce 6 ☐ Other (Speci	60
on of	tending Physideath.  tor: After this if the funeral directions of the funeral directions.	ion: To	27. Manufer of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		28d. Describe ho	- ' '	<i>y</i> /
JON Divisio	or A after Direct in by	Medical Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Str City or Town	reet and Number or Run , State)	al Route Number,
00	Hos Hos Fun tely	dical (		cian: To the best of my knowledge, dea or: On the basis of examination and/or in and manner stated.				
9	To the Hos within 24 hd To the Fun completely	Me	29b. Signature and title of dertifier	W	29c. License number	29	ed. Date signed (Month,	Day, Year)
	3		30. Name and address of person who com	pleted cause of death (Item 23a) (Type,	et wolf ut	5 DC	2003/	,
	Sta Registr		31. Date filed (Month, Day, Year)	Registrar's Signature	who strip	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		

Amended Item 23A Part I Lines a,b,c 07/08/2008 Carroll Co., wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Per Physician State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** July 4, 2008 1951 Michael Belt Greenwood, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westminster Carroll Carroll Hospital Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 XM 2 □ F 1950 Maryland Director 57 Nov 6213-60-5675 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Examiner must be froithed at 1 ☐Yes 2 No Director Maryland Finksburg Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21048 2533 Old Kays Mill Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. Specify: ⋧ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) JMZ, Inc. 12 Master Plumber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental F John D. Greenwood Doris Louise Belt ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health in tem 27 l permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr Finksburg, MD 21048 V. Gail Greenwood wife 2533 Old Kays Mill Rd. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Evergreen Mem Garden: 7/9/2008 Finksburg, Maryland 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Simatur of Prineral Service Lie -K 412 Washington Rd. Westminster, MD 21157 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Spont aneous Rupture of Pancreatic Pseudocyst Immediate Cause (Final disease or condition resulting in death) **Physician** CHILINE /Medical Due to (or as a consequence of) **Examiner** 1 Week Acute Pancreatitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine 6 Months Chronic Pancreatitis burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 TYes Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔼 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 07/02/2008 homas k. Colles 14 m NJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas K. GAlvin III, ID

State Registrar

31. Date filed (Month, Day, Year)

JUL 08

2008

DHMH 17 Rev 1/2001

Hospital or Attending Physician: The law requires that the death certificate be executed

the

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Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

2115)

STOWER AVENUE informinister manyland

32. Registrar's Signature

		1	_ State CA	artment of Health and Me ertificate of Death	ntal Hygiene	2008 23580
			Registrar  1. Decedent's Name (First, Middle, Last)	2	Date of Death Month Day	3. Time of Death
	Physicia /Medic		Betty Ann Gordy		7 2	2008 1:10 A M
The same of	Examin	er '	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death Orcester
-			Atlantic General Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Berlin    If Under 1 Year   If Under 24 Hrs.   8		9. Birthplace (State or Foreign
	Funeral Director		214-34-7772 1□ M 2♥ F 70 Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Year) 11/1/1937	Country) MD
	D		Usual Residence of Decedent			10d. Inside City Limits
	arylan <b>show</b> d at		10a. State 10b. County 10c. City, Town or 1			1 □Yes 2 ☑ No
110	he Me	Director	MD Worcester Berl  10e. Street and Number	10f. Zip Code	10g. Citiz	zen of What Country?
0	with t		10559 Windmill Rd.	21811	l	JSA
	ms 23	Funeral		. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No-	14. Race - American Indian, Black, White, etc.
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Modolf Expring must be called at	व	1 ☐ Never Married 2 🔀 Married  3 ☐ Widowed 4 ☐ Divorced  Affined Folces:  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 □Yes 2 🗷 No Specify:		Specify: white
2-0	72 hou	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kir	nd of Business/Industry
7	ithin 7 ne. han "	g l	Elementary/Secondary (0-12)   College (1-40r 5+)	nemaker		n Home
2	filed within Hygiene.		17. Father's Name (First, Middle, Last)		First, Middle, Maiden	
lan	Should be filed within and Mental Hygiene. is marked other than aumatic event, It was	To Be	Archie Bishop	Pearl Ma		
Maryland 21215-0036	id 2 shouth and N			ling Address (Street and Number or Rural 559 Windmill Rd., Be		
45	of Health of Health if item 27 is		20a. Method of Disposition 20b. Place of Disposition	position (Name of Da ematory or other place)	te 20c. Lo	ocation - City or Town, State
E C	Page: nent o nt: If iry or			le Cemetery 7/5/2	008   Lit	pertytown, MD
Baltimore,	permit. Pages 1 Department of H Important: If ite any in ury or ot		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Bu 108 William St., Be	rbage Fund erlin, MD 2	
			25a Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
	Physician	i i		eer		Onset and Death
	/Medical		resulting in death)  Due to (or as a nsequence of):			
	Examiner	<u>ب</u>	Sequentially list conditions, let any leading to immediate b. Due to (or as a consequence of):			
	ted 1sit	nin e	cause. Enter Underlying Cause (Disease or injury			
	execunand and al-train	Examiner	that initiated events resulting in death) Last c			
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical	d			
9	ntifical ng phy as th	/ledi	IE SEMALE.			
Box	leath certifica attending ph I for use as th	Physician/Med		3 ☐ Ectopic pregnancy		23d. Date of delivery  Month Day Year
0.	hed fo	/sici	1 □ Yes 2 No 9 □ Unknown	5 Other (specify)		
σ.	v requires that the description is been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
gs	uires n sign ld be	d b	Emonic Obstructive Pulmonon	y disease	1 Yes 2	□ No 3 □ Probably 4 □ Unknown
of Vital Records,	w req	Completed by	,	,	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Be	o <del>_</del> o	I W			performed2 1 □ Yes 2 No	death?
ita	ician; The certificate ector, pag	a)	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
) _	Physician: r this certific ral director,	To B	1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpa		ne 5 Residence	
		i.i	27. Manner of Death 1 Natural 5 □ Pending (Month, Day, Year)  28b. Tim (Month, Day, Year)		8d. Describe how inju	ny occurred
Sio	Attending ir death. ector: Afte by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury - At home, farm		8f. Location (Street a	nd Number or Rural Route Number,
Division	lor A after Direc	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		City or Town, Stat	re)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only (Ch	eath occurred at the time, date and place, a r investigation, in my opinion, death occurre	and due to the cause( ed at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
	the Fithin 24	Medi	one) and manner stated.  29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)
	5 ¥it 5 10 10 10 10 10 10 10 10 10 10 10 10 10		M.D	D006412	0 -	7/2/08
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	BALO		zeeshan, Atit Day 9733 1	tealth wall) nivi	e isenti	DID FUU X (81)
	St Regis	tate trar	31. Date filed (Month, Day, Year)  32. Registrar's Signature	Sperti		

DHMH 17 Rev 1/2001

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Beth, A. Cordy 214-34-772

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 23581 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** June 27, 10:50 AM Η. John Hosey 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1164 Regal Oak Drive Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours Min. 72 426-66-2468 March 14, 1936 Mississippi Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County Department of Health and Mental Hygiene. Important: if items 23a or 28a-f show any injury or other traumatic event, Ite Medical Exprinst must be notified at any injury or other traumatic event, Ite Medical Exprinst must be notified at once. Director 1XYes 2 □ No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1164 Regal Oak Drive 20852 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify. þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Medical Specialist US Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Buria Lee Hosey Winifred White ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renata B. Greenspan-Wife 1164 Regal Oak Drive\_ Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State Arlington Nat. Cem. July 14,2008 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia Goldberg Mem. Chapels, Rockville, MD 20852 21. Signature of Funeral Service License 22. Name and Address of Facility Danzansky Inc. 1170 Rockville Pike Donald ( 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician Merkel Cell Carcinoma 33 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a P.0. 1 ☐ Yes 2 ☐ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by icate has been sig page 2 should by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No certificate I 1 ☐Yes 2 ☐ No 1 □ Yes Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) spital or Attending Plours after death.
neral Director: After t 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 24 hours a To the Hospital within 24 hours a To the Funeral C 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 31266 27,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeremy G. Perkins, MD 6900 Georgia Avenue, NW Washington, DC 20307 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State JUL 0 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 200<sup>8</sup>8ar CHARLES Н. HILL 8:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day Year) Aug. 28,1916 England 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 91 Months Days Hours Min 1 XM 2 □ F 208-03-1524 Yrs Director Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Exaramer, ust be notified at 1 ☐Yes 2 X No Director MD Germantown Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or is marked other than "natural", or Items 23a or is any injury or other traumatic event, the Wedical Event and its best once. 18989 Abbotsford Circle 20876 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No 1941— IfVes, Give Year or Dates: 1945 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 X No Specify: Specify: White Ş Q 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Negative Engraver Army Map Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Hill Emily Nave 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles W. Hill (Son) 18989 Abbotsford Circle, Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July Date 5 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Alexandria, VA Metropolitan Crem. 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📉 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🛛 No 1 □ Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral ( 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural iours after death. neral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

certificate

this

After

the Maryland

Baltimore, Maryland 21215-0036

12+1

within 24 hours a

MD 5859 80-40-50 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Shahryar Davari M.D. 15225 Shady Grove RD. #208 Rockville, MD 20850

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

State Registrar

Medical

31. Date filed (Month P)

determined

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier



12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

		State of Maryland / Department of Hea		ıl Hygiene	2008	23583
		1 - State Registrar Certificate of De		Reg. No	2000	
Physic	cian	1. Decedent's Name (First, Middle, Last)	Mor	e of Death nth Da	y Year	3. Time of Death
/Mec	dical	Nerissa N. Harris  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Loc	Ju.	<del></del>	008 County of Death	5:20p M
Exam	iner	Larkin Chase Nursing Home Bowie			rince G	eorge!s
Funera	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Yea	Under 24 Hrs. 8. Date	e of Birth	9. Birthp	lace (State or Foreign
Directo		578-04-6653 1 M 250 F 87 Yrs. Months Days H		nth, Day, Year) e 30 • 1	921 Ja	imaca
and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				0d. Inside City Limits
Aaryla f sho	ō	MD Prince George's Upper Marlboro	)			1 □ Yes 2 ŽiNo
the h	rec	10e. Street and Number 10f. Zip Code		10g. Cit	tizen of What Coun	itry?
h with	Funeral Director	217 Graiden Street 20774		ن ز	Jamaica	
ems (	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispar Armed Forces? 13. Was Decedent of Hispar If Yes, specify Cuban, M	anic Origin? (Specify Yes	s or No-	14. Race - Americ Black, White, e	
s after	by F.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No St	Specify:			an Indian
5-UUSO 72 hours at natural", or	pa	3 ☑ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation	SD.	16h K	ind of Business/ind	dustry
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d with	Completed	8 Homemaker		JO V	vn Home	
ING Z I Z I 3-UU.30 be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Modical Exemplar must be natified at	Be		. Mother's Name <i>(First, i</i> Lucinda Ho		Surname)	
aryla should I and Men marke umatic	2					
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s 1 ar		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		ocation - City or To	
attimor rmit. Pages ' partment of l portant: If ite y injury or of		1 X Burial 2 □ Cremation 3 X Removal from State 4 □ Donation, 5 □ Other (Specify)	y 7/19/20	08 S	panish T amaica	l'own,
Date  permit. Departe Imports any inju	ġ	21. Signature Funeral Service Line 26ee 21. Signature Funeral Service	TNALDI FUI	NERAL	SERVICE	,P.A.
n goe 2	a	1 9241 Columb	bia Blvd.	Silver		,Md20910
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line.	·			Approximate Interval Between Onset and Death
Physiciar /Medica	_	Immediate Cause (Final disease or condition resulting in death)  Complications from Hepa	tic Cirrh	osis		
Examine		Due to (or as a consequence of):				
	je 📕	Sequentially list conditions, if any, leading to incrediate cause. Enter Underlying Cause (Disease or injury				
ecuted nd iransif	Examiner	that initiated events C				
cate be executed physician and the burial-transit	Ě	resulting in death) Last Due to (or as a consequence of):				
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ath certifi	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	20/
w requires that the death certifications is been signed by the attending should be detached for use as	sician/Me	23b. Was decedent pregnant in the past 12 months?  1			Month	Day Year
by the tache	Phys	9 Unknown				
es the igned be de	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Part I. 23e		use contribute to th	
ord requir een s rould				1 ☐ Yes 2	□ No 3□ Prob	pably 4 🚰 Unknown
necolds, ne law requires t has been signe	Completed		248	a. Was an autopsy	prior to co	psy findings available mpletion of cause of
al r				performed? Yes 2 No	death? 1 □ Yes	2□No
sicial sicial certifi	Be	examiner?	6. Place of Death (Check			
ding Physician: The law h h Affer this certificate has funeral director, page 2.9	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	4 Nursing Home 5 ☐ 28d. De	Residence scribe how inju		<u>v)</u>
Attending r death. ector: Afte by the fune	atio		3 2 □No			
r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Loc City	ation (Street ar	nd Number or Rura	l Route Number,
urs aff				_		
To the Hospital or Attending Physician: The law requires that the death certifications of the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier  (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, of the basis of examination and/or investigation, in my opinion and manner stated.	date and place, and due on, death occurred at th	e to the cause(s e time, date an	s) and manner as s d place, and due to	tated. the cause(s)
Fo the vithin or the omple	Mec	29b. Signature and title of certifier 29c. License nur D 4 3 3	ımber	29d. Da	ite signed (Month,	Day, Year)
		D433	) bl	J	uly 7,20	800
Q		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
		Ikechi Okwara MD 6201 Greenbelt Rd. S	Suite U15 G	reerbe	1t, Md 20	)740
	tate	31. Date filed (Month, Day, Year)  32 Registrar's Signature				
Regis	mar	JUL 0 8 2008 Solver S. Specter				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Mariorie Bride Felix Heavey 3:00 p /Medical July 5. 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2908 Covington Road Silver Spring 8. Date of Birth (Month, Day, Year March 22, Montgomery Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) Days Hours 1 □ M 2 🛣 F Yrs 217-36-8591 71 1937 Director Pennsylvania Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland fith end Mental Hyglene. Fit Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Pladical Ess. Julyar must be retified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show 1 XXes 2 □ No Directo Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2908 Covington Road 20910 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2√ No If Yes, Give Year or Dates: <u>ک</u> 1 ☐Yes 2 No White Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health end Menta Important: If Item 27 Is marked any Injury or other traumatic ev Paul Gerard Felix ဂ္ Dorette Bride 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Moffett/Daughter P.O. Box 541, Garrett Park, MD 20896 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State July 7 4 □ Donation 5 □ Other (Specify) Alexandria, Virginia Metropolitan Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, Husu M MD 20901 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Probable Acute Myocardial Infarction Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Atherosclerotic Coronary Artery Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Essential Hypertension Years and burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate 1 ☐ Yes 2 🗆 No 2 **1** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation I 🙀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the I within 2 To the I and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of

State \* Registrar

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Records,

of Vital

Division

Mary Lee Kwok,
31. Date filed (Month, Day, Year)

30. Name and address of person who impleted cause of death (Item 23a) (Type, Print)
Mary Lee Kwok, MD 6900 Georgia Avenu

Registrar's Signature

VA101242467

6900 Georgia Avenue, NW, Washington, DC 20307

July 7, 2008

08-04975 Darrell C. Hoes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 23585

		- For State		Ce	rtificate of	Death			R	teg. No.	000	<i>)</i>		
Physicia		legistrar  1. Decedent's Name (First, Middle,Last)  2. Date of Day  Month Day										. Time of De	ath	
ledical Examir		DARRE	LL C.	HOES					Month June 27.	Day Yea 2008		1313 hrs	;	
		4a. Facility Name (if not institution	on, give street and n	umber)		4b. City, Town, or	Location of			4c. County c	f Death			
		3400 Glen Avenue	, g., 1,	,		Glendale				Prince G	eorge's	3		
			To o		to at tale to a		If Under	24Hea I	Date of Pi	irth(MM/DD/YYYY			or Foreign	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	iast birthday)	If Under 1 Year Months Days						itry) ish. I		
Director		577-78-7810	1 X M 2 F	49	Yrs		1.00.0		Aug.	,1958	wa	ısn. I	)C	
	<b> </b>	Usual Residence of Decedent	<u> </u>											
any		10a. State 10b. County		10c. City	, Town or Locat	ion		-	_			0d. Inside C		
<u>*</u> .		MD Pr:	ince Geo		Gle	ndale						1 X Yes	2 No	
daryland 28a-f show 1 at once.	힀	10e. Street and Number				10f. Zip Code			- 1	10g. Citizen of Wh	at Countr	v?		
r 28	Director					l '	- 0					,		
15-0036 filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f sho , the Medical Examiner must be notified at ones.	_ 1	3400 Glen	Avenue			2076				U.S				
ms 2	Funera	11. Marital Status		cedent Ever in U		is Decedent of His es, specify Cuban					- America e, etc.	an Indian, Bla	ick,	
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fer i	1	3 Widowed 4 Di	vorced If Yes, Give Ye	ar	1	Yes 2 X No	specify:			Specify:	BI	.ack		
urs a fora	d b	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of votation most of working life. DO NOT use retired to the property of the prope								16b. Kind of Bu	siness/In	dustry		
2 hours "natur	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)							1)	Prin	ce G	eorge	es l	
5-0036 led within 72 Hygiene. other than '	호	4 yrs Appeals Coordina								Co G	over	nment		
l with	탉	7. Father's Name (First, Middle, Last) 18. Mother's Name												
<b>元</b>	Be C											er	ŀ	
21215-0036 ould be filed within 7 Mental Hygiene. s marked other than ic event, the Medica		9a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or F								Cvangeline A. Walker				
MD 2 2 shoul th and N 27 is m umatic	F	200 II wand Drive											205	
e, MD 1 and 2 sho Health and litem 27 is	1	James Hoes	(Father	1006		sition (Name of ce			Date	20c. Location			703	
Fire free		20a. Method of Disposition  1 Burial 2 Crematic	n 3 Demoval		crematory or of	her place)					,	,	ļ	
Baltimore, MD 2121 pernit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,				A:	rdent	Cremati	n Sit	v 7	7/8/0	8 Hand	ver	, MD		
Ty arithme or a second	1	4 Donation 5 Other 3	Lice ee	1	22.1	Name and Address	of Facility	GM	OWDEN	N FUNER	ΔT. E	OME	DΔ	
Baltimore, M permit. Pages 1 and 2 Department of Health. Important: If item 2 injury or other traum	· J	LUMA K	AMINIA	Neu II						Rocky				
		23a. Part I. Enter the disease, of	r complications that	caused the deal	th. Do not enter	the mode of dving.	such as ca	ardiac or r	espiratory a	rrest, shock, or he	art	Approximat		
Physician /Medical		failure. List only one caus	e on each line.			, 3.						Between C		
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		or condition resulting in death)	•	a consequence	of):									
	ا۔	Sequentially list conditions,	b. Dilated Ca		0						_			
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	핆	(Disease or injury that initiated events resulting in death) Last		a consequence	of):									
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760, ficate be executed g physician and sthe burial - transit	n/Medical	UNPENDED	AMENDED											
O, e be ysicia	edi									22d Date o	f dolivon			
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certi certi mdin use a	<u>.</u>	past 12 months?		nant at time of		ther (Specify)		p. vg.	-,			,		
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O. B. It the de	문	Part II. Other significant cond	litions contributing	to death but not	resulting in the	underlying cause	given in Pa	art I.	23e. Did	tobacco use cont	ribute to t	he cause of	death?	
P.O.	ą								1 Y	'es 2 No 3	Prob	ably 4 🗸 l	Jnknown	
S, P quires t an sign ald be o	Completed by								24a. Wa	esan 124h	Were auf	opsy finding	s available	
ords, w requir is been s should	e e								aut	opsy	prior to co	ompletion of		
Recc The lavicate ha	E									formed?	death? 1 ✔ Ye:	s 2	No	
tal Rection: The certificate ector, page		25. Was case referred to medic	cal			26.Plac	e of Death	(Check or	niy one)					
ital F sician: s certifi irector,	Be	examiner?	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA	Other,	Nursing	Home 5	Residence 6	✓ Other	: Scene		
Division of Vital Records, tal or attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should t	ဥ	1 V Yes 2 No 1 Impatient 2 Exodupation 3 DOA 4 Ituising notice 5 Nesidence 5 V C 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred												
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or A	ij	3 Suicide 6 Could not be determined determined (Specify)							ber or Rui	iai Route Nu	iber, City			
Di Rospital 24 hours a Funeral I	Certification:	4 Homicide	termined (Specif	y)										
24 h 24 h Fun		29a. Certifier 1 Certifying	Physician: To the b	est of my knowle	edge, death occ	urred at the time, o	ate and pla	ace, and d	lue to the ca	ause(s) and manne	er as state	ed.		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a	Medical	one) 2 Medical Ex	xaminer:On the basi and manner	s of examinatior · stated.	and/or investig	ation, in my opinio	n, death oc	curred at	the time, da	ite and place, and	due to the	e cause(s)		
_ ` ` ` ` `	Me	29b. Signature and title of certi				29c. Licen	se number			29d. Date sig	ned (Mor	nth, Day, Yea	-)	
10	(OLLE) HALLOW O.C.M.E. June 28, 2008													
4 -		20 Name and address of	on who completed as	use of dooth /#	om 23a)							-		
		30. Name and address of personal Allan, MD A				Street Baltin	ore MF	21201						
S	tate	31. Date filed (Mantis, Day, Yea	3 2008   24	registral s sign	O. Don	all I								

			For State	State of	f Maryland / Dep			Mental Hyg	iene		
			Registrar  1. Decedent's Name (First, Midd.	llo ( cot)	Ce	ertificate of	Death	2. Date of Dea	eg. No. 2	08 23	586
	Physici	an			no Honkino			Month	Day	Year	D M
	/Medic Examin		4a. Facility Name (If not institution		ne Hopkins	4b. City, Town, o	r Location of Deat	<u>June</u>	28 20 4c. County	008 10:17	/ 1
1	Examin	er o	Cherry Lane N		,	Laure	1		Princ	ce George's	2
-	Funeral		5. Social Security Number		7. Age (In yrs. last birthda	/) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	. (Month, Day	Year)	9. Birthplace (State o	r Foreign
4.55	Director		422-56-9599	IL M 224 F	66 Yrs.			Feb. 23,	1942	Lisbon, AL	4
	land w		Usual Residence of Decedent  10a. State 10b. County	/	10c. City, Town or	_ocation				10d. Inside Ci	ty Limits
	Mary -f sho fied a	ģ	MD Monts	gomery	Rur	tonsville				1 XIYes	2 🗆 No
	or 28a	irec	10e. Street and Number	<u> </u>	2742	10f. Zip Code		1	I0g. Citizen of V	/hat Country?	
	23a c	Funeral Director	14501 Wexhall	Terrace		208			U.:		
	tems	nne	11. Maritai Status	Armed Fo	edent Ever in U.S. 13 prces?	B. Was Decedent of H If Yes, specify Cub	lispanic Origin? (s an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race Blac	e - American Indian, k, White, etc.	
36	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show ther, the Medieal Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☑ Divorce	If Yes, Giv	ve	1 ☐ Yes 2X No	Specify:		Specify	Black	
215-0036	2 hou atura cal E		15. Deceder	nt's Education	16a. Dec	edent's Usual Occup	oation	- 1	16b. Kind of Bu	siness/Industry	
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and	be fil ntal H ed ott	B	17. Father's Name (First, Middle					me (First, Middle,		e)	
Maryland	hould id Me mark matic	မ	Thomas Ruffin  19a. Informant's Name/Relation		-	iling Address (Street		an Seymou		State, Zip Code)	
Ma	nd 2 s Ilth ar 27 is rtrau		Kelli Y. Hopk		•	1 Wexhall				. ,	
ē,	of Heal		20a. Method of Disposition	_	20b. Place of Dis	position (Name of rematory or other pla	i	Date		City or Town, State	
E	Page nent c		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (		State	ke Cremat	ory 7/3	/2008	Belts	ville, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service		•	22. Name and Addre	ess of FacilityMc	Guire Fur	neral Se	rvice, Inc	
8	20 E # 9			hompson						on, D.C. 20	
	* Topic		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that can only one cause on e	caused the death. Do not e each line.	enter the mode of dyt	ng, such as cardia	ac or respiratory an	rest,	Approximat Interval Bet Onset and I	e ween Death
,	Physician /Medical	ı	Immediate Cause (Final disease or condition resulting in death)		Lications fro (or as a consequence of):	m Acute M	yelogeno	us Leuke	mia		_
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	icate be executed physician and s the burial-transit	Examiner	lany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
68760,	be execian a	E	resulting in death) Last	Due to	(or as a consequence of):						
387	physicate I	dical		d							
Box 6	leath certifi attending p	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome pf pregnancy				23d. Da	te of delivery	
	death	icial	in the past 12 months?	4□Pregi	nant at time of death	3 □Ectopic pregnand 5 □ Other <i>(specify)</i> _	у		Mo	nth Day	Year
P.0	that the ed by the detache	hys	9 🗆 Unknown	9□ Unkn							
	w requires that the de been signed by the should be detached	by F	Part II. Other significant condit	•	•	underlying cause gi	ven in Part I.			ribute to the cause of o	
Records,	requires een sign	ted	Diabetes Mel		1 Neuropathy					3 □ Probably 4x	Jnknown
3ec	2 38	nple	Major Depres	sion				24a. Was autop	sy	Were autopsy findings prior to completion of c death?	available ause of
<u>a</u>	iclan: The certificate ha ector, page		05.111					1□ Yes	2 🔀 No	1 ☐ Yes 2 ☐ No	
or Vital	Physician: this certific ral director,	o Be	25. Was case referred to medic examiner?  1 ☐ Yes 2X No	Hoenital:	Inpatient 2 ☐ ER/Outpat	ient 30 DOA Ott	hor:	eath (Check only o		or (Specify)	
ō		ت: ا	27. Manner of Death	28a. Date		of 28c. Inju		T	now injury occur		
Division	Attending r death. ector: Afte by the fune	atio	Z L Accident	tigation		M 1	]Yes 2□No				
ivis	r Atte	tific	3 Suicide 6 Could 4 Homicide deter	d not be mined 28e. Place build	e of injury - At home, farm, ling, etc. (Specify)	street, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	er or Rural Route Nun	nber,
	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical Certification:	One Continue A M Continue								
	Hosp 24 hou Fune stely fi	lical	29a. Certifier 1 ♣ Certify (Check only 2 ■ Medica	al Examiner: On the b	e best of my knowledge, de basis of examination and/o nner stated.	eath occurred at the tring investigation, in my	opinion, death oc	ce, and due to the curred at the time,	cause(s) and made date and place,	anner as stated. and due to the cause(	s)
	othe othe	Mec	29b. Signature and title of certif	h //	The stated.	29c. Licen	se number		29d. Date signe	d (Month, Day, Year)	
	- 310		· All	DAN	1/	ב י/ע	351		July 2	. 2008	
	>		30. Name and address of perso	n who completed cau		e, Print)					
			Dr. Ikechi Fre		6201 Greenbe	elt Rd., S	Suite U-l	5 Colleg	e Park,	MD 20740	
	St Regist	ate	31. Date filed (Month, Day, Yea	2008 32	egistrar's Signature	Casti )					

			1- State of Maryland / Departr	ment of Health and Mo icate of Death	ental Hygiei	ne2008	23587
	Physici		1. Decedent's Name (First, Middle, Last)  Ruth Bernice Holsinger		2. Date of Death Month July 11	Day Year	3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street and number)  Homestead Manor  5. Social Security Number  6. Sex 7. Age (In yrs. last birthday)  M M	onths Days Hours Min.	8. Date of Birth (Month, Day, Ye	4c. County of Death  Carolin  (ar)  9. Birthpl  County	e lace (State or Foreign try)
	ש	rector	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland Caroline Denton			O18 Mary	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "netural", or Items 23e or 28e-f show other treumatic event, it is Madical Examinational be indifficial.	Completed by Funeral Director	410 Colonial Drive  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Education 16. Decedent Ever in U.S. 13. Was 16. Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Decedent Ever in U.S. 16. Was 16. Decedent Ever in U.S. 16. Decedent Ever in U.S. 17. Was 16. Decedent Ever in U.S. 18. Was 16. Decedent Ever in U.S. 19. Was 18. Was 18. Decedent Ever in U.S. 19. Decedent Ever in U.S. 19. Was 18. Decedent Ever in U.S. 19. Decedent Ever in U.	21629  E Decedent of Hispanic Origin? (Speas, specify Cuban, Mexican, Puerto F  Yes 2 No Specify:  'S Usual Occupation of of work done during most of workin  NOT use retired)	cify Yes or No- lican, etc.)	14. Race - America Black, White, s Specify: Cau	casian ustry
yland 21	2 should be filed with and Mental Hygien Is marked other the	To Be Cor	17. Father's Name (First, Middle, Last)  Charles Hugh Smith	Care Caseworker 18. Mother's Name Jeanet	(First, Middle, Maid te Bro	own	
Baltimore, Mar	permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is m any injury or other treum <u>once.</u>			ory`or other place)	, Marylan	nd 21843 Location - City or To	
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service Licensee  22. Na  Moc  12  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the	ame and Address of Facility			and 21629 Approximate
58760,	cate be executed // Medical bhysician and bhysician and street burial-transit	dicai Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or knur) that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C				Interval Between Onset and Death
.O. Box 6	death certiff e attending ed for use as	Physician/Med		topic pregnancy her (specify)		23d. Date of delive Month	ny Day Year
Records, P.	The law requires that the de ate has been signed by the a page 2 should be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	1 ☐ Yes		ably 4 □Unknown
ital Rec	ien: The law rtificate has b stor, page 2 s	3e Completed	25. Was case referred to medical	26. Place of Death	24a. Was an autopsy performed 1 Yes 2 (Check only one)	prior to con death?	psy findings available inpletion of cause of
Division of Vital	Attending Physicien: The I death. octor: After this certificate ha by the funeral director, page	Certification: To B	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation  3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street,	28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No		njury occurred t and Number or Rura	
Ö	To the Hospitel or Attending within 24 hours after death. To the Funeret Director: After completely filled in by the fune		4  Homicide building, etc. (Specify)  29a. Certifier (Check only 2  Medical Examiner: On the basis of examination and/or investi	curred at the time, date and place, a	City or Town, S	e(s) and manner as st	ated.
)	To the Hospitel within 24 hours a To the Funeret I completely filled	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, I	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Prin Metinde Butter 13th Leanum	nt)	1	21655	5
	Sta Registi		31. Date filed (Month, Day, Year)  JUL 1 4 2008  32. Registrar's Signature				

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F rtificate of		nental Hy	/giene Reg. No. 2	100	22500
ŀ	H		Decedent's Name (First, Middle, Last	st)				2. Date of D		1 U O	3. Time of Death
	Physicia /Medic	_	Johnnie Ray	Hyson,	Sr.				1/2008	Year	6:26 P M
	Examin	er	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Death			y of Death	
			4281 Maryland Hi 5. Social Security Number 6. S		e (In yrs. last birthday	0aklan	If Under 24 Hrs.	8. Date of Bi		rrett	-l (C4-4 5
	Funeral Director		577-40-3787	M 2□F	75 Yrs.	Months Days	Hours Min.	(Month, D	ay, Year)		place (State or Foreign ntry) t Virginia
	fand ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	Mary Ff sh	tor	MD Garret	t	0aklan	1					1 □ Yes 2 No
	th the or 28¢	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?
	ath wi		4281 Maryland Hi	ghway			21550			ISA	
0	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Eximiner must be notified at	/ Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent if Armed Forces?  1 X Yes 2 1 If Yes, Give	10	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	o- 14. Ra Bla Speci	ack, White,	
3	hours tural";	d by	3 Widowed 4 Divorced	Year or Dates:			v, 39,			Wh	ite
2	n 72 "nat ledle	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	edent's Usual Occup e kind of work done DO NOT use retire	pation during most of work d)	ing	16b. Kind of E		ndustry
7 7	withi	mo	Elementary/Secondary (0-12) 8th	College (1-4or 5	+)	h Supervi			Juvenil		rvices
2	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r traumatic event, the Med	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam			me)	
<u></u>	uld be Menta arked	70	Warren B. Hyson	1			Madale	ean S	haffer		
<u></u>	2 sho and 1 is ma		19a. Informant's Name/Relationship (	Type. Print)	19b. Mail	ing Address (Street	and Number or Rui	ral Route Num	ber, City or Town	ı, State, Zij	p Code)
≥ '`	l and lealth m 27 her tr		Carla A. Hyson /	wife		Maryland					
5	ages 1 nt of h i if ite or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐			osition (Name of ematory or other pla		Date	20c. Location		
Daltillo	it. Pa intmer intant injury		4 □ Donation 5 □ Other (Specifical Service Licer	··		rk Cemete 2. Name and Addre		/2008			Maryland
0	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Turiera Service Licer	1/15					Funeral Oakland.		yland 2155(
F			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused							Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Lung Car	ncer with						Onset and Death 1 Year
	Examiner			Pac 10 (01 do	a consequence ory.						
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):						
	ecute ind transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
Š	be exician a	Ē	resulting in death) Last	Due to (or as	a consequence of):						
00/00	ificate be executed g physician and as the burial-transit	edical	•	d						-	
O. DOX O	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at g □ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	у			ate of deliv	very Day Year
_	s that ti ned by e detac	by Phy	Part II. Other significant conditions of	contributing to death be	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco use cor	ntribute to	the cause of death?
colds,	en sig							1 🔀	Yes 2□ No	3 ☐ Pro	babiy 4 Unknown
טטט	he law ra e has be ige 2 sho	Completed						per	formed?	death?	opsy findings available ompletion of cause of
ומו	an: T tificati tor, pe		25. Was case referred to medical				26. Place of Dea		2 X No	1 🗆 Yes	2 No
	nysici lis cer direc	To Be	examiner? 1 ☐ Yes 2 <b>X</b> ) No	Hospital:	nt 2 ER/Outpatie	ent 3 DOA Oth	or.		sidence 6 🗆 Ot	ther (Spec	ify)
5	ng Pt fter th neral		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry 28b. Time ( Year) Injury	of 28c. Inju	ry at rk?	28d. Describe	how injury occu	ırred	
2	eath. Ior: A	catic	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □ No				
2	after d Direct Jin by	Certification:	4 Homicide determined	28e. Place of inju- building, etc	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location City or To	(Street and Num own, State)	iber or Rui	ral Route Number,
	Hospita 24 hours Funeral	Medical C	29a. Certifier (Check only one)  1	nysiclan: To the best of miner: On the basis of and manner sta	examination and/or i	th occurred at the ti nvestigation, in my	ime, date and place opinion, death occu	, and due to th rred at the time	e cause(s) and n e, date and place	nanner as	stated. to the cause(s)
	ro the ro the comple	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date sign	ed (Month	, Day, Year)
			Round Dans	Mos	100	Н	26154		7/1	4/08	
	10+11	A	30. Name and address of person who Dr. P. Daniel Mil		eath (Item 23a) (Type 69 Wolf A		, Oakland	. Marv	land 21	550	
9	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	1. 100.		y			
	Registr	ar	JUL 1 5	2008	Secret Secretary						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Year Physician 8:00 PM HARABOSKY JOSEPH Juli /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** CRCII VA Maryland Health Care System Point Herry If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. OCT 13, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 PA 6. Sex 1 XX 2 □ F **Funeral** Director 222 20 0248 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1

Yes 2 No MD CECIL PERRY POINT 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 1 any injury or other traumatic event, the Medical Examinar must be 1 once. 21902 BROAD STREET USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1955— 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 WHITE 1 ☐ Yes 2 🗓 No Specify: ģ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER CARPENTRY Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARA BOSKY JOHANNA HERLIHY ROMAN HARABOSKY ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLOVER LANE, NEWARK, DE 19713 EDWARD HARABOSKY - BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place)
FAMILY CREMATION
SERVICES 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8 WILMINGTON, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses <sup>22</sup>. Name and Address of Facility
MEALEY FUNERAL HOMES
PO BOX 2866, WILMINGTON DE 19805 M00784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ancer disease or condition resulting in death) LIKHOWA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): death certificate be executed attending physician and for use as the burial-transi-Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day signed by the a 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 XNo has After this certificate 2 No 1 Yes 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aff completely filled in by the fur 1 ☐Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my reliable death. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannerstated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

Z+ / VA State

Registrar

Ihomas

VA Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

1)42800

Health Care System

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Margaret Elizabeth **Physician** Hopkins July 9 2008 9:40A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Caroline Ruxton Health of Denton Denton 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, Apr. 1, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 87 Months Days Hours 1 □ M 2 🖺 F 218-16-9599 Apr. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 TYPes 2 □ No MDDorchester Hurlock Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 72 hours after death with 4713 Jackson Street 21643 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: B1ack Specify: \$ 3√ Vidowed 4 Divorced Year or Dates: permit. Pages 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural" any Injury or other traumatic event, the Medical Expone. "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Processing Factory Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilbur Butler Maggie Brown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerome Hopkins, Sr./Son 4713 Jackson St., PO Box 611, Hurlock, MD 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 07/18/08 Eastern Sh. Veterans Cem. Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> Framptom Funeral 216 N. Main St., Federalsburg, of Funeral Service Licenses va 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final KNEUMONIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine attending physician and for use as the burial-transit he law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a 9 Hunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ t BRO VASCULAR 1 Yes 2 No 3 Probably 4 Unknown t een si Completed 24a. Was an Were autopsy findings available prior to completion of cause of s certificate has t lirector, page 2 s autopsy performed? Yes 2 No death? 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of certifie

State Registrar

DHMH 17 Rev 1/2001

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 🔊 🎧 🤉 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7/1272008 5:50 P M Antonio Dewayne Harris, Jr. /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Memorial Hospital at Easton 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/12/2008 7. Age (In yrs. last birthday) **Funeral** Maryland Days 1 M 2□F **NONE** Yrs. Director Usual Besidence of Decedent death with the Maryland 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State r than "neturel", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Grasonville **Funeral Director** Maryland Oueen Anne's 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 215 Evans Avenue 21638 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1□Yes 2♥No Black Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked othe eny injury or other treumetic event 20x8. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Heather Thomas Antonio Dewayne Harris, Sr. ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 Evans Avenue, Grasonville, MD 21638 Heather Thomas/Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 7/13/2008 Cambridge, MD Mid Shore Cremation Center \*4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service License 22. Name and Address of Facility Mid Shore Cremation Center, 2272 Hudson Rd., Cambridge, MD 21613 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) prior to viability Pnysician delivery premature /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Completed by Physiclan/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) I□Yes 2□No July the 9 Unknown 12 2008 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1 TYes 2X No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: P 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Yes 2 ER/Outpatient 3 DOA this I Director; After this od in by the funeral o 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending 2 No death. investigation 1 Yes 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a To the Funerel ( 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier BW 1658105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S W2000 Jashungton 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Thomas, BABY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8

			1 – For State Registrar	State of Maryland	l / Depa <i>Cer</i>	rtment of h	Health and <i>Death</i>		giene2 ()	08	23592
	Physicia		1. Decedent's Name (First, Middle, Last) Frederick Herman	Jaeger			· · · · · · · ·	2. Date of Dea	ath	Year	3. Time of Death 8:00 pm
	/Medic Examin		4a. Facility Name (If not institution, give s Shady Grove Adven			4b. City, Town, c		ath	4c. County Montg		у
	Funeral Director		5. Social Security Number 6. Sex 063-07-9365		97 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	n (Month Da	h y, Year) <b>7,</b> 1910	Coun	place (State or Foreign htry) York
	hours after death with the Maryland tural", or items 23a or 28a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgome:		Town or Loc	eation cy Villag	ge			11	0d. Inside City Limits 1 □Yes 2 🔼 No
	ith the	Funeral Director	10e. Street and Number			10f. Zip Code	206		10g. Citizen of V		
	eath v	eral	19310 Club House	Koad I2. Was Decedent Ever in U.S	13 V	208		(Specify Yes or No-	United	e - Americ	
020	should be filed within 72 hours after death with the Marylan nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", in remarked other than "marked other "	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 □ Yes 2 ♣ No If Yes, Give Year or Dates:	lf	Yes, specify Cub	an, Mexican, Pu	erto Rican, etc.)		k, White, e	
21215-0036	thin 72 hore.	Completed	15. Decedent's Educ (Specify only highest grade	College (1-4or 5+)	(Give I life. E	ent's Usual Occup kind of work done OO NOT use retire	pation during most of w d)	vorking	16b. Kind of Bu		
7	led wil lygien her th ht, in		47 Falls of New (Fine) I finding to an)	2	Sales	Manager	40 Mathada N	lame (First, Middle,			Equipment
yıand	should be fi and Mental F s marked ot umatic ever	To Be	17. Father's Name (First, Middle, Last) Herman Jaeger				Marg	aret Jord	lan		
Mar	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Ty	·		-		Rural Route Numbe rkway, Po			
<u>6</u>	f Heal f Heal ftem 2 other		John Jaeger  20a. Method of Disposition	` '				Date y /,	20c. Location -		
Ē	Pages nenton nr: 17 o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Met	ropoli emator	sition (Name of latory or other pla Ltan Y	20	.y /,	Alexand	ria.	Virginia
Банттог	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service License	7	22	. Name and Addre	ess of Facility	DeVol Fur Drive, Ga	neral Ho	me,	MD 20877
	hysician		23a. Part 1. Ther to disease, or complinate, or hear railure. List only or immediate Larse (recomplinate disease of condition)	cations that caused the death. e cause on each line. Respiratory			ng, such as card	liac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a conseque		-					
	Examiner		Sequentially list conditions,	Cardiac Arre							
	nsit	nine	Sequentially list conditions, if any, leading to immediate cause for the driply Cause (Disease or injury that initiated events	Due to (or as a conseque	ence of):						
<u>.</u>	execu in and iaf-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):			·			
	ificate be executed physician and is the burial-transit	dical		Congestive H	eart I	Failure					
O. BOX	Attending Physician: The law requires that the death certificate the state of the attending ector. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 □	Ectopic pregnand Other (specify)	су			te of delive	ery Day Year
Sp.	quires that n signed b ald be deta	by	Part II. Other significant conditions cor Coronary Artery	_	ting in the un	derlying cause giv	en in Part I.				he cause of death? bably 4™ Unknown
Records,	The law rei	Completed							rmed?	Were auto prior to co death? 1 ∐Yes	opsy findings available impletion of cause of
VITA	stan: ertifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of D	1 ☐ Yes Death (Check only o		10163	2010
> i	hysic this ce al dire		1 Yes 2 TNo	·	R/Outpatien		4 L Nursing	g Home 5 Resid			fy)
	After After funera	ion	27. Manner of Death  1   ↑ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Inju Wor M 1	ryat rk? ]Yes 2 ∐No	28d. Describe l	now injury occur	ed	
DIVISION	to the hospital or futending Physician: The living to within 24 bours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page:	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre		1163 2	28f. Location (3 City or Tox		er or Rura	al Route Number,
-	lo the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical C	29a. Certifier 1 Certifying Physical Certifying Physical Examination (Check only one)	sician: To the best of my know ner: On the basis of examinati and manner stated.	/ledge, death on and/or inv	occurred at the t	ime, date and pl opinion, death o	ace, and due to the ccurred at the time,	cause(s) and m date and place,	anner as s	stated. o the cause(s)
	Io th withir To th comp	Me	29b. Signature and title of certifier	-		29c. Licens	se number		29d. Date signe	d (Month,	Day, Year)
	10					1057			Jul	.y 4,	2008
	, 2		Dr Ahmed	mpleted cause of death (Item	9	715 M	ledica.	1 Center	Dr R	XXU	ille 20850
	Sta Registr		31. Date filed (Month, Day, Year)	32. Régistrar's Signatu	ire	carta)					

Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar AMENDED #8 PER FH 7/10/08 Certificate of Death CCHD AS Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** MICHAEL PAUL **JOSEPH** 03, JULY 2008 6:45 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CAROLINE HOME FOR HOSPICE DENTON, MARYLAND
If Under 1 Year If Under 24 Hrs. 8. D CAROLINE COUNTY 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months Min 221-52-9073 49 **Director** SEAFORD, DE Usual Residence of Decedent the Maryland worde! 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health and Menial Hygiene.
Item 27 is marked other then "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Directo MARYLAND CAROLINE COUNTY **GREENSBORO** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 518 BERNARD **AVENUE** 21639 UNITED STATES death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Completed by If Yes, Give Year or Dates: Specify: WHITE Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if tem 27 ie marked other then "na eny injury or other traumatic even." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER/MECHANIC HOSPITAL MAINTENANCE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RONALD L. JOSEPH. REBA ပ ELLIOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHELLEY JUMP JOSEPH (WIFE) 518 BERNARD AVE.; GREENSBORO, MD 21639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CAREY'S CEMETERY JUL 09,2008 MILLSBORO, DE 21. Signature of Runeral Service Licens 22. Name and Address of Facility MO 1361 WATSON FUNERAL HOME P.O. BOX 125 MILLSBORO, DE 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carcinoma **Physician** Metastastic Colorectal disease or condition resulting in death) years 9months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certiticate be executed Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐ Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform med' 1 Yes 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death | Check only one examiner Other: 4 Nursing Home 5 Residence 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) HOSOICE this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred house 28c. Injury at Work? After 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after death Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Suite 302 Easton, MD State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 6:35 p Nellie Jordan July 4 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 515 Apple Grove Road Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M **XX**F Director 150-03-4648 92 April 5, 1916 New York Usual Residence of Decedent 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits show 10a. State 10b. County event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 👿 No 28a-f Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò USA , or items 23a 515 Apple Grove Road 20904 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ½ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify: δ White 3 ₩ Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 2 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Harris ٩ Nellie Yarrow 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret J. Antonisse/Daughter 1903 August Drive, Silver Spring, MD 20902 Department of Health Important: If item 27 any injury or other to once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ⊈ Cremation 3 ☐ Removal from State July Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia ature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final >Physician disease or condition resulting in death) Alzheimer's Disease vears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause in the Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760 Physician/Medical the attending p IF FEMALE yes, outcome of pregnancy

Live birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 **X**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Natural Natural 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a cal 29a, Certifier 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D09834 July 7, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3720 Farragut Avenue, Kensington, MD 20895 Barry Rosenbaum, MD 31. Date filed (Month, Day, Year) egistrar's Signature State JUL 0 8 2008 Registrar

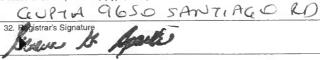
State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month O S 20.35P M **Physician** JUNE WALTER KELLEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Columbia Howard Howard County General | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Days | Min. | Jan 21, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**☑** M 2□ F 87 420-52-8021 Alabama Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f show Silver Spring Montgomery 1 ☐ Yes 2 No Md Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20902 USA 10601 Lester Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑Yes 2 □ No1 9 4 1 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Black ō If Yes, Give Year or Dates: Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Military Serviceman U.S.Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be file and Mental File is marked ott Alice Young Perk Vickers ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $210\overline{2}9$ 19a. Informant's Name/Relationship (Type. Print) 5709 Whistling Winds Walk Clarksville, Md. Health tem 27 i Warren Kelley/Son permit. Pages 1 am Department of Heal Important: If item 2 any Injury or other once. 8/05% 2008 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Remyoval from State Arlington Nat'l Cem Arlington, Virginia 4 ☐ Donation 5/1 Other (Specify) PANETE PADDES RICHALDI FUNERAL SERVICE, P.A. eral Service License 21. Signature of Fe 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the stease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 0945 RENAL CELL CARCINOMA **Physician** METASTATIC /Medical Due to (or as a consequence of) DAYS Examiner ADPINATION Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician: The law requires that the death certificate be executed DEMONZIA Physician/Medical Exami Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes 2√□Mo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide 29a. Certifier and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JUNE 30 200 8 SUITELLO NEL 00053150

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Baltimore, Maryland

Box 68760X

P.O.

of Vital Records,

Division

			For State Registrar	State	of Marylar		artmen <i>rtificat</i>		lealth and l Death	Mental Hy	giene Reg. No.2 (	800	235	96
Ľ,	Physicia	20	1. Decedent's Name (First, Middle,	Last)						2. Date of De Month	ath Day	Year	3. Time of	
¥.	Physicia /Medic			OSE			1 0	KEL		07	12	08	2140	Рм
	Examin	. (3)	4a. Facility Name (If not institution, WMHS BRADDOCK	CAMPUS			CUI	MBER			AL	ty of Death		
	Funeral Director		5. Social Security Number 212-38-6255	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. 68		) If Under Months	Days	If Under 24 Hrs. Hours Min.	(Month, Da	th y, Year) st 06, 1939	9. Birthj Cou	olace (State o ntry) Marylai	r Foreign nd
	and w		Usual Residence of Decedent  10a, State 10b. County		10c. Gi	ty, Town or L	ocation						10d. Inside Cit	ty Limits
	Maryli f sho	tor	Maryland	Allegany					Frostburg	<b>.</b>			1 □Yes	2 No
	n the	Director	10e. Street and Number				10f. Zip	Code			10g. Citizen o	of What Cou	ntry?	
	23a c 23a c ust be		19503 I	Buskirk Holl					21532		1.4		SA	
36	ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show rother traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marrie	Armed F ed 1 Tes If Yes, G	2 ☑ No Sive	I.S. 13.	Was Dece If Yes, spe 1 Yes		Ispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Spe	ace - Ameri lack, White, cify:		a
Ş	hours tural'	ed b	3 XWidowed 4 ☐ Divorced  15. Decedent	Year or	Dates:	16a. Dece	edent's Usu	al Occup	ation		16b. Kind of	Business/Ir	111.000	,
<u>.</u>	in "na In "na Medic	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed	(1-4or 5+)		e kind of wo DO NOT u	se retired	•	_	ĺ			
7	ed with	Com	12		0			Diet	ary Departm				ood	
and	be file	Be	17. Father's Name (First, Middle, I		d Ziler				18. Mother's Nar	,	, <i>Maiden Surn</i> arie Rose			
2	hould id Mei marke matic	욘	19a. Informant's Name/Relationsh		- Carlot	19b. Maii	ing Address	(Street	and Number or Ri				p Code)	
Σ	nd 2 s alth ar 27 is ir trau			eller, Jr So	on		195	03 B	ıskirk Hollo	w Road, Fr	ostburg, N	Marylan	d, 21532	
Baltımore,	ges 1 a it of Hez <b>if Item</b> or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	2 Damayal from		Place of Disp cemetery, cr	osition (Nai	ne of other plac	ce)	Date	20c. Locatio			
Ĕ	Pages ment of lant: If its		4 □ Donation 5 □ Other (Sp	ecify)	Il State		berland			July 13, 2008			nd, Maryl	
Rail	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service L	lilhom	1			8	ss of Facility East Main S	Street Lone			39	
9.			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dea each line.	th. Do not e	nter the mod	de of dyir	ng, such as cardia	c or respiratory a	arrest,		Approximate Interval Bet Onset and I	a ween Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	_a S	o (or as a consec	S	mor	om	e				2we	oks
	Examiner				1 2 22 760	hdem	inal	a	bscess				2we	cks
	p ti	iner	Se juentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		U (UI do a CUITORI	quence of).	1.	. 1.	0				211.50	
Ď.	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDr	o (or as a conse	quence of):	div	2h	culum					cks
8760,	ate be	dical		d										
X	certific Iding p	/Med	IF FEMALE:	23c. If yes, c	utcome pf pregr	ancy					23d.	Date of deliv	verv	
C. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		e birth 2  Fet gnant at time of known		□Ectopic p □ Other (s					Month	,	Year
ds, P.	w requires that been signed by should be deta	by	Part il. Other significant condition	ons contributing to	death but not res	sulting in the	underlying (	ause giv	en in Part I.		tobacco use c Yes 2 □ No			leath? Jnknown
Records,	v requ been should	letec								24a. Was	an 24	b. Were aut	opsy findings	available
		Completed			-					auto	opsy ormed? 2 No	prior to co death? 1 ☐ Yes	opsy findings ompletion of c 2000	ause of
Vital	sician certifi irector	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospital:	√Inpatient 2□	]ER/Outpatio	ent 3⊡ D	Oth	OF.	ath (Check only		Other (Core	26 A	
on or	ding Phys I. After this funeral di	ion: To	27. Manner of Death 1 Natural 5 □ Pending	28a. Dat	te of Injury onth, Day Year)	28b. Time Injury		28c. Inju	4 🗀 Nursing i	Home 5 ☐ Res 28d. Describe			iry)	
Division or	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director.	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determi	ot be 28e. Pla	ce of injury - At h Iding, etc. (Spec	nome, farm, s ify)	-			28f. Location City or To	(Street and Nu wn, State)	mber or Ru	ral Route Nun	nber,
	Hospita 24 hours Funeral etely filled	edical C		g Physician: To t Examiner: On the and ma										5)
	To the within To the comple	Mec	29b. Signature and title of certifier		7 .		29	c. Licens	se number		29d. Date sig	ned (Month	, Day, Year)	
)			monson	hefh	n 1	40		0	00553	325	Tul	u 13	,200	8
		4	30. Name and address of person	who completed ca				eИ	00553 PD C	cimal-a-	lune 1	Jun	2/50	7
	Sta	l l	31. Date filed (Month, Day, Year)	M	Pegistrar's Sign	LSHOP nature	WAL	>r]_	MU (	WINDEN	unce	MI	430	
	Sta Registi		JUL 1's	5 2008	The same of the sa	DE A	South	D						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar	Department of Health and M Certificate of Death	Reg	ne No. 2008   3 2 mm/15 best 7
Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year
/Med Exami		Fdward F . Kwas  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	July 9	2008 3:23 A M 4c. County of Death
LABITI	e e	10236 New Forest Court	Ellicott City		Howard
Funeral Director		5. Social Security Number  102 32 8362  Usual Residence of Decedent  6. Sex 12 M 2 F 69	Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 07–07–19	9. Birthplace (State or Foreign Country) New York
yland low at		10a. State 10b. County 10c. City, Town	n or Location		10d. Inside City Limits
e Mar a-f sh	ctor	SC Georgetown Pawle	ys Island		1 □Yes 2 X No
ith th	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
sath v s 23a nust	era	98 Coleman Court  11. Marital Status  12. Was Decedent Ever in U.S.	29585	acifu Vec or No	United States  14. Race - American Indian,
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural" or Items 23a or 28a-f show out, the Medical Ex-miner must be notified at	Funeral	11. Marital Status  1 □ Never Married 2√ Married  1 □ Never Married 2√ Married  1 □ Never Married 2√ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2√ Married  11. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
O36	b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1962–64	1 ☐ Yes 2X No Specify:		Specify: White
5-0 72 ho 72 ho dical	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing   16	b. Kind of Business/Industry
within ene.	m d	Elementary/Secondary (0-12) College (1-4or 5+) 4 A	ssistant Commissione:		S Customs Service
Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mental Hygiene. t? Is marked other than "natural" or traumatic event, the Medical Ex mi	Be Co	17. Father's Name (First, Middle, Last)		(First, Middle, Mai	
/lar	To B	_ Edward F. Kwas, Sr.	Lucy Kwa	sniewski	
ING, Maryland 21215-0036 Is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminer must be notified at	ľ		. Mailing Address (Street and Number or Run		. ,
t and thealth em 27 other tr			Coleman Court Pawle		, SC 29585 c. Location - City or Town, State
Baltimore, permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		1 ☐ Burial 2XI Cremation 3 ☐ Removal from State	ry, crematory or other place)		,
Baltin permit. P Departme Important any injury once.		4 Donation 5 Other (Specify) Arden  21. Signature of Funeral Service Licensee M01044			anover, MD zke's Family FH Inc.
Balt permit. Depart Import any inj		Them Collins - White MOI 044	4112 Old Columbia	ry H. Wit Pike Elli	cott City, MD 21043
bayon, ilicate be executed / Medical Examiner    By physician and    By the burial-transit    By	cal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Lipiesase or infinity that initiated events resulting in death) Last  Due to (or as a consequence of the conditions) of the conditions	of):	or respiratory arrest	Approximate Interval Between Onset and Death 6 mon the
death certif e attending d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
dS, F.O. uires that the de signed by the ad doe detached for the signed by the signed by the signed for the sig	b	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?  2 No 3 Probably 4 Unknown
VITAI MECORDS, P.O sidan: The law requires that the certificate has been signed by the rector, page 2 should be detache	Completed			24a. Was an autopsy performe	
ysicia ysicia is certi	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	Othor	n (Check only one)	e 6 Mother (Specify) son's home
o f fe		27. Manner of Death 28a. Date of Injury 28b. T	- I I I I I I I I I I I I I I I I I I I	28d. Describe how	
LIVISION I or Attending after death. Director: Afte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
Hospita 24 hours Funeral etely filled	edical C	29a. Certifier (Check only one)  1 **Scertifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	, death occurred at the time, date and place, d/or investigation, in my opinion, death occur	and due to the caus red at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	29c, License number	29d.	Date signed (Month, Day, Year)
		Hosalyn Jungeno up	D 60203		July 9, 2008
1541		, 30. Name and address of person who completed cause of death (Item 23a) (			21231
(40		Rosalyn Juergens 1650 orleans Stra  31. Date filed (Month, Day, Year)  32. Poster's Signature	ect Johns Hopkins Cl	LBI-693	Baltimore, Maryland
St Regist	ate rar	JIII 0 9 2008	Let Johns Hopkins Cr Aparle		•

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 2,2008 2:50a M Siamayatu Lebbie 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Washington Adventist Hospital Takoma Park 8. Date of Birth

Jan • 1,1994 5 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours Min. Months Sierra Leone 1 ☐ M 2 🔀 F 63 214-67-6114 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Montgomery Silver Spring 1 ☐ Yes 2 XNo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Sierra Leone 20902 11302 Monticello Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛂 No Black Specify Specify: 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kumba Kema Lebbie Sahr Lebbie Kokotowa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20902 19a. Informant's Name/Relationship (Type. Print) 11302 Monticello Avenue Silver Spring, Md Tamba Yabba/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Jown, State Kono, Gandor hun, 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Penoval from State 7/18/2008 Sierra Leone Family Cemetery 4 □ Donation 5 □ Other (Specify) PHIMIP ADIERINALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final theumonia disease or condition resulting in death) Due to (or as a consequence of): Congestive Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Hinknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□Yes 2 No 1 □ Yes 2 □ №6 25. Was case referred to medical 26. Place of Death (Check only one)

**Physician** /Medical **Examiner** 

ending physician and use as the buriaf-tran

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requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

I or Attending Physician: after death, Director: After this certifica funeral director,

To the Hospital within 24 hours a To the Funeral Completely filled

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Certification: To

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exertiner must be notified at

I Hygiene. should be filed within

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permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 Yes 2 No

5 Pending

27. Manner of Death investigation 6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only

29a. Certifier

2 Accident

3 Suicide 4 Homicide

> 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
> 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

D62475

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7600 Carroll Ave. Takoma Park, Md. onarine Anand

State Registrar

2008 0.8



For State Registrar Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Day **Physician** Robert Lee Lurensky 2008 4, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Suburban Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Month, Day, May 5, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F 80 033-20-6983 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examins in unat be notified at once. 10a State 10c. City, Town or Location 10b County Bethesda Maryland Montgomery Director 10f. Zip Code 20817 10e. Street and Numbe 10g. Citizen of What Country? United States 7520 Holiday Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No ģ If Yes, Give 1958**-197**8 Specify. Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Economist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Celia Kamm Lurensky Abraham ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor G. Lurensky -wife 7520 Holiday Terrace Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place)
King David Mem. Gardens 7/7/2008 20c. Location - City or Town, State 3 Removal from State Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of)

Due to (or as a consequence of)

attending physician and for use as the burial-tran

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7/4/08

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Physician/Medical cate has been signed by the page 2 should be detached à Completed funeral director, Be Certification: To To the Hospital or Attending Playin 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral

IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Parkinson's Disease; Anemia, Coronary Artery Disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? vz. autopsy performed? Yes 2 No 2X No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

29b. Signature and title of certifier MD

29c. License number D0060117

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29d. Date signed (Month, Day, Year) July 5, 2008

23599

3. Time of Death

19:15 P.™

Massachusetts

White

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 □Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

8600 Qld Georgetown Road Bethesda, Maryland 20814 Eric J. Park, M.D.

State Registrar

29a. Certifier

(Check only one)

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year 3:15 pM Helen Carolyn Lyman 2008 July 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Chevy Chase Montgomery 8607 Springdell Place 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗷 F Yrs. Director California 72 September 5, 1935 553-44-2758 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Montgomery Chevy Chase 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20815 U.S.A. 8607 Springdell Place Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces 72 hours after 1 □Yes 2 🗷 If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Caucasian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) iene. Elementary/Secondary (0-12) College (1-4or 5+) International Educator U.S. State Department d 2 should be filed w. th and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked < any Injury or other traumatic eve once. Sidonia Baum ျှ Adolph Ermann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8607 Springdell Place, Chevy Chase, Maryland 20815 Princeton Lyman - Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cemetery 07/08/2008 Adelphi, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Colon Cancer resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ling physician and e as the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) Ö 1 ☐Yes 2 🗷 No 9 Unknown 9 Unknown signed by t ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ₹ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) Hospital 1 Tes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 XNatural 5 ☐ Pending investigation hours after death. neral Director: Ai y filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and 29c. License number 29d, Date signed (Month, Dav. Year) DC19655 July 7, 2008 0

DHMH 17 Rev 1/2001

State

Registrar

3800 Reservoir Avenue, Washington, DC

ress of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signat

John Marshall, M.D.,

0 8 2008

31. Date filed (Month, Day, Year)

JUL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	_1	For State Registrar  Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Death		2360 3. Time of Death					
Physician /Medical Examiner	ıl r	William Francis Millo a. Facility Name (If not institution, give street and number)  Reninsula Regional Medical Celebration	4b. City, Town, or Location of Death		Day Year ZOOB  4c. County of Death						
Funeral Director	5	. Social Security Number 6. Sex 7. Age (In yrs. la: 220–60–7585 1 ★ 2□ F 55	110	8. Date of Birth (Month, Day, ) 9/24/19!		place (State or Fore intry) Yland					
a-f show	_ 1	,	Town or Location			10d. Inside City Lim					
ritems 23a or 28a-f s ingravest be notified Fineral Director	al Dire	0e. Street and Number 36398 Old Ocean City Road	g. Citizen of What Cou USA	intry?							
o. 1	2	1. Marital Status  1 □ Never Married 2 □ Married  3 🏿 Widowed 4 □ Divorced  1. Was Decedent Ever in U.S. Armed Forces?  1 ☒ Yes 2 □ No If Yes, Give Year or Dates: Army	. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 □ Yes 2 ▼No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: wh	ican Indian, etc. ite					
ygiene. her than "natura it, the Midical E	mbiered	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)  fork liftoperator	king	6b. Kind of Business/Ir						
Mental Hygi arked other atic event, To Be C.	ဗ္ <b>ဂ</b>	7. Father's Name (First, Middle, Last) William Francis Milleker	18. Mother's Nan	ne (First, Middle, Ma Sanders							
27 is ma er trauma		19a. Informant's Name/Relationship (Type. Print) Yevette E. Kiser/daughter	19b. Mailing Address (Street and Number or Ri 36398 Old Ocean City	Rd., Wil	City or Town, State, Zi lards, MD	21874					
	2	T Burial 2 (Acremation 3 Li Removal from State	nce of Disposition (Name of metery, crematory or other place)  lisbury Crematory 6/1		Oc. Location - City or T						
important: li any Injury o once.	1	21. Signature of Funeral Service Utensoe	22. Name and Address of Facility HOLLOWAY Funeral 501 Snow Hill Rd.	Home Profe	essional A	ssociation					
physician and support the burial-transit and the burial-transit and colored Examiner	Examiner	Due to (or as a consequence of any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events esulting in death) Last  Due to (or as a consequence of a conseque	ence of):  L Ischemia								
been signed by the attending physicic should be detached for use as the bu should be detached for use as the bu leted by Physician/Medical	ysicialirimeur	F FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □Yes 2 □No 4 □ Pregnant at time of decent and the second s	23d. Date of delivery Month Day Year								
n signed by	ລ   ່	Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given in Part I.		acco use contribute to						
ate has page 2			prior to condeath?  □ No 1 □ Yes								
Fig. 15	2		R/Outpatient 3 DOA Other: 4 Nursing H		ice 6 ☐ Other (Spec	ify)					
The The	במוכוו	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 5 Homicide 6 Sea. Place of Injury - At home, farm, street, factory, office 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Describe how injury occurred Work?									
ctor.	=	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as s									
ctor.											
within 24 hours arter dearn.  To the Funeral Director. After completely filled in by the funeral Medical Certification:	enical		ledge, death occurred at the time, date and place on and/or investigation, in my opinion, death occurred at the time, date and place on and/or investigation, in my opinion, death occurred and place of the place of								

08-05337		Please Type or	Print in Black Indeli	ble Ink. Ensure All Copies	Are Legil	ole.	0.060		
Jaelynn Monet M			of Maryland / Departme	ent of Health and Mental Hyg ate of Death		200	8 2360		
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	Certifica	2	Reg. Date of Death		3. Time of Death		
Medical Examir		Jaelunn	Monet Mc	Kenzie	Month Day	ay Year B	2237 hrs		
4		4a. Facility Name (if not institution, give Anne Arundel Medical Cent		4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel			
Funeral		Social Security Number     6. Sex	, , ,	nday) If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	,	MM/DD/YYYY) 9. Birt Foreig	n		
Director	4	Usual Residence of Decedent	M 2 F	Yrs. 6	July 3	2008 Co	intry) Maryland		
' any	-	10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits		
ne Maryland or 28a-f show	5	MD	Gra	asonville			1 Ves 2 No		
Maryland r 28a-f sh	Director	10e. Street and Number	A A .	10f. Zip Code	10g.	Citizen of What Cour	itry?		
ith the notifi	=	4-A Fisher		13. Was Decedent of Hispanic Origin? (Spe	sifu Ves er No	14. Race - Ameri	oon Indian Black		
death with the Maryland or items 23a or 28a-f sho	Funeral	1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto F		White, etc.			
			f Yes, Give Year or Dates:	1 Yes 2 V No specify:			ack		
"natu	ted	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	y highest grade completed) 16a. I College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of wo during most of working life. DO NOT use retire	ork done	6b. Kind of Business/I	ndustry		
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after treat of Health and Mental Hygiene. Sant: If item 27 is marked other than "natural", or other transmatic event, the Medical Examiner.	Completed by	Clementary/Secondary (0-12)	```	Veven worked		N/A			
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D 2121 should be fil and Mental I 7 is marked	Be	19a. Informant's Name/Relationship (Ty	ee	o. Mailing Address (Street and Number or/Ru		nzie	Zin Code\		
MD 21 12 should th and Me 127 is ma numatic ev	۵	To L. Ala V	pe, Fillit)	L-A Fisher Manor	Graso		10 2/638		
ore, MIss I and 2 so of Health a If item 27 ner traum:		20a. Method of Disposition		f Disposition (Name of cemetery,	Date 2	Oc. Location - City or	Town, State		
Baltimore bermit. Pages 1: Department of Hi important: If it		1 Burial 2 Cremation 3	Tellioval Ironi State	ory or other place) Son's CeMetery 7/1	17/08	Srasonvi	110 110		
Baltimor Permit. Pages Department of Important: If	ľ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens		22. Name and Address of Fi cility	1.000	A	116, 7010:		
E E E E		Janelle C.	Henry	Henry Funeral/	Sti Ca	ubridge	MD.21613		
Physician /Medical		failure. List only one cause on each	h line.	it enter the mode of dying, such as andiac or	respiratory arrest	, shock, or hear	Approximate Interval Between Onset and		
kaminer	1 3		probable digeorg	e anomaly	_		Death		
		Sequentially list conditions, b	de to (or as a consequence or).						
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	xaminer	(Disease or injury that initiated C	ue to (or as a consequence of):		· · · · · · · · · · · · · · · · · · ·				
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	Physician/Medical	XUNPENDED	AMENDED 23a,2/,per	ME, g882 8/12/08 TT					
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X 6	icia	past 12 months?	4 Pregnant at time of death		•				
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of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be execute. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - tran	ē	Part II. Other significant conditions	contributing to death but not resulting	g in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death?  1 Yes 2 ✓ No 3 Probably 4 Unknown			
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COF e law r e has b	直				autopsy perform	ed? death?	completion of cause of		
I. The lifficate or, pag		25. Was case referred to medical		26.Place of Death (Check o	1 Yes 2	No 1 🗸 Y	es 2 No		
/ita //ita //is cer directe	m		ospital: 1	lou.		esidence 6 Othe	r:		
of N	n: 7	27. Manner of Death	28a. Date of Injury (Month, Day, Year) 28b.	Time of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred			
ion ttendii leath. tor: /	atio	Natural 5 Pending 2 Accident Investigatio		1 Yes 2 No					
Division of Vital Records, P.O. Box 68760 sopial or Attending Physician: The law requires that the death certificate be hours after death.  Ineral Director: After this certificate has been signed by the attending physisy filled in by the funeral director, page 2 should be detached for use as the but	Certification:	3 Suicide 6 Could not b	e 28e. Place of Injury - At home, fa	arm, street, factory, office building, etc.	28f. Location (Str or Town, Sta		ural Route Number, City		
Hospi 24 hou Funer tely fil	al Ce	29a. Certifier Certifying Physicia	n: To the best of my knowledge, dea	ath occurred at the time, date and place, and	due to the cause(	s) and manner as star	ed.		
To the within To the Comple	Medical	one) 2 Medical Examiner:	On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred at					
H S H S	ž	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mo	nth, Day, Year)		
				O.C.M.E.		July 12, 2008 			
OCME	-	30. Name and address of person who can Mary G. Ripple MD. Dep	ompleed cause of death (Item 23a) uty Chief Medical Examiner	111 Penn Street, Baltimore, M	D 21201				

State Registrar

DHMH 17 Rev 1/2001 OCME 2006

31. Date filed (Month, Day, Year)

			For State	State of Maryla	•	artment of H				23603	
c	Physici		Registrar  1. Decedent's Name (First, Middle,	Last) M / L x	00	rinicate of t	Jean	2. Date of Dea Month	Day Year	3. Time of Death	
	/Medic Examin	al -	4a. Facility Name (If not institution,	give street and number)	7	4b. City, Town, or	r Location of Death	July	2 2008 4c. County of Deat		
	Fundad		39/ QUSSE// 5. Social Security Number 6	S. Sex 7. Age (In yrs	s. last birthday)	Gar X	If Under 24 Hrs.	Date of Birth	9. Birt	thplace (State of Foreign	
	Funeral Director		579-03-9013 Usual Residence of Decedent	1□M 2 <b>X</b> F 9	5 Yrs.	Months Days	Hours Min.	JUNE 2		IRGINIA	
	anyland •how		10a. State 10b. County		City, Town or Lo					10d. Inside City Limits 1▼ Yes 2 No	
	r 28a-f	Director	MD • MONTGO	MERY		GAITHERSI 10f. Zip Code	BURG		10g. Citizen of What Co		
	eath wit		301 RUSSELL	AVE.	US 13		0877	pecify Yes or No-	U.S		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 ie marked other than "natural", or Iteme 23a or 28a-f ehow mingorient: If Item 27 ie marked other than "natural", or Iteme 23a or 28a-f ehow my njury or other traumatic event, I're Madical Exertificated to mailified at ance.	by Funeral	1 Never Married 2 Marrie  3	Armed Forces?	0.3.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No		o Rican, etc.)	Black, Whit		
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	filed wi Hygien other th		12 17. Father's Name (First, Middle, La	ast)		SECRETAI		ne (First, Middle,	CHURC Maiden Sumame)	·H	
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	and 2 sho salth and n 27 le m		19a. Informant's Name/Relationshi		19b. Maili 244				r, City or Town, State, . RO VALLEY,		
Baltimore,	Pages 1 and named to the month of them bent: If Item bury or other		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3	3 □Removal from State	cemetery, cre	osition (Name of matory or other place		Date	20c. Location - City or		
altin	Department Important Important Important Outco	i	4 □ Donation 5 □ Other (Special Signature of Funeral Service Line)		2	RS CREMATO	ss of Facility		RIVERDALE,		
aa ■	89 = 9	. 0	23a. Part1. Enter the disease, or c						REMATORIUM, RDALE, MD.	Approximate	
	Physician		shock, or heart failure. List or Immediate Cause (Final disease or condition	ity one cause on each line.	t for	ilur	eto!	rig	<b>8</b>	Interval Between	
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):	i ao	loas	reck		mT	
W.	ad sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):					I mod		
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<u>م</u>	uires that signed b d be deta	d by Pł	Part II. Other significant condition	s contributing to death but not re	esulting in the i	underlying cause giv	//	230. Did to	obacco use contribute t res 2 ☑ No 3 ☐ P	o the cause of death?	
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tal R		е Соп	Strikey  25. Was case referred to medical	entres			26 Place of De	perform 1 ☐ Yes ath (Check only o	rmed death?	s 2 No	
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Division	or Atte after de Directo in by th	Certification:	3 Suicide 6 Could no 4 Homicide determin	building, etc. (Spe	28e. Place of Injury - At home, farm, street, factory, office 28f. Location (			28f. Location (S	(Street and Number of Rural Route Number, own, State)		
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	12		30. Name and address of person w	,	em 23a) (Type		2010		July 3	10000 NUC -	
			4.2052R	TBIRSCHB	AKH	, ald	GALT	RUSSE HERSB	URG, nr	120877	
The state of	Sta Registi		31. Date filed (Month, Day, Year)	7 2008 32. Registrar's Sig	mature	Special					

			For State Registrar	Sta	ate of Ma	aryland / De <i>C</i>	partment of I <i>ertificate of</i>	Health and N <i>Death</i>	Mental Hyg ғ	giene Reg. No. 20 (	08 23604
	Physic	ian	1. Decedent's Name (First, M				2. Date of Dea Month	I I I	/ear		
1	/Medi	cal	Margaret Mothershead  4a. Facility Name (If not institution, give street and number)  4b. City, Town, c						July	02 26 4c. County of	008 6:02 a M
	Exami	ner		versfield l			AD. Oity, TOWIT, C	Hyattsville			nce George's
	Funeral		5. Social Security Number	6. Sex 1 □ M 2		(In yrs. last birthda	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	(, Year)	9. Birthplace (State or Foreign Country)
	Director		218-20-1604 Usual Residence of Deceder	t		80			November	8, 1927 I	Pennsylvania
	rryland show	<b></b>	10a. State 10b. Co	unty		10c. City, Town or	Location				10d. Inside City Limits
	with the Maryland a or 28a-f show	Director		Prince Geor	rge's		1.00 = 0.00	Hyattsville			1 ☐ Yes 2 🗷 No
	with t		10e. Street and Number	versfield l	Drive		10f. Zip Code	20782	1	I0g. Citizen of Wh	at Country?
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examirer must to notified at	Funeral	11. Marital Status	12. Wa	as Decedent E	ver in U.S. 1	3. Was Decedent of I If Yes, specify Cub		pecify Yes or No-		American Indian,
36	s after de , or items	by Fu	1 Never Married 2 🗷	Married 1 [	]Yes 2 🛣 N ′es, Give	lo	1 ☐ Yes 2 ♣ No	Specify:	nican, etc.)	Specify:	White, etc.
9	72 hours "natural",		3 ☐ Widowed 4 ☐ Divo	rced Ye	ar or Dates:	16a. De	cedent's Usual Occup	pation		16b. Kind of Busi	White ness/Industry
215	thin 72 e. an "ng Media	Completed	(Specify only h Elementary/Secondary (0-	ighest grade comp	oleted) llege (1-4or 5-	(Gi	ve kind of work done . DO NOT use retire	during most of work d)	ring	Top: Time of paoi	need made by
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Maryland 21215-0036	12 should be filed within 72 hou th and Mental Hygiene. T is marked other than "natura traumatic event, It a Mudich E	Be	17. Father's Name (First, Mic		_			18. Mother's Nam		Maiden Surname)	
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	1 and 2 Health a em 27 is		Andrew Mothers	head - Husl	band		2 Eversfield				
Baltimore,	8 = = 0		20a. Method of Disposition 1   ■ Burial 2 □ Cremat	ion 3 ☐ Bernova	al from State	20b. Place of Dis	position (Name of ematory or other pla	ce)	Date	20c. Location - Ci	ity or Town, State
ij	permit. Page Department of Important: If any Injury or once.		4 □ Donation 5 □ Othe	er (Specify)		Fort Line	coln Cemeter		08/2008	Brentwood,	Maryland
Ba	Depa Depa Impo any I		21. Signature of Funeral Ser	T. Klol	iect		22. Name and Addre Hines-Rinal 11800 New H	di Funeral	Home, Inc enue, Silv	ver Spring	, Maryland 20904
			23a. Part 1. Enter the diseas shock, or heart failure.	e, or complications List only one caus	s that caused se on each line	the death. Do not e e.	enter the mode of dyi	ng, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Lung Ca						1 month
	Examiner					Obstructiv	e Lung Disea	90			Years
	D .±	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Ь		consequence of	c hang bisco				Tours
	ecute and trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	) to (or on o	consequence of):					
68760,	ificate be executed g physician and as the burial-transit	al E	,	consequence or).							
	E 00 88	fedical	15.55141.5	u							
Box	death certif e attending d for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 1		2 ☐ Fetal death :	B ☐ Ectopic pregnanc	y		23d. Date of	
Ö	0 O	ysic	1 ☐ Yes 2 🚾 No 9 ☐ Unknown		☐ Pregnant at ☐ Unknown	time of death	Other (specify) _			Worth	n Day Year
о. С.	The law requires that the ate has been signed by the bage 2 should be detache	by Ph	Part II. Other significant con	ditions contributir	ng to death bu	t not resulting in the	underlying cause giv	en in Part I.	23e. Did tol	bacco use contrib	ute to the cause of death?
of Vital Records,	w requires to been signer should be a	ed b							1 🗷 Y€	es 2 □ No 3	☐ Probably 4 ☐ Unknown
Sec	e law r has be	Completed							24a. Was a	y prio	ere autopsy findings available or to completion of cause of
alF	n: The ficate r, page								perförr 1 □ Yes		ath? ]Yes 2 □ No
Ζ	Physician: this certific	o Be	25. Was case referred to med examiner? 1 ☐ Yes 2 ☒No	lical Hospital	: 1 🗆 Innetion	nt 2 ☐ ER/Outpat	ant 3 DOA Oth	er:		·	
ا م	ding Physician: The In. After this certificate hare funeral director, page	Certification: To	27. Manner of Death		. Date of Injury (Month, Day,	y 28b. Time	of 28c. Injur	4 LI Nursing Ho		ence 6 Other ow injury occurred	(Specify)
Sior	or Attending after death. Director; After in by the funer	catic	Z LI MODICOIN	estigation	(Monn, Day,	reary mijary		Yes 2 □ No			
Division	or Att	ırtifi		ermined 28e.	Place of Injur building, etc.	y - At home, farm, s (Specify)	street, factory, office		28f. Location (St Cify or Town	reet and Number n, State)	or Rural Route Number,
_	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 X Cert	fying Physician:	To the best of	f my knowledge, de	ath occurred at the ti	me, date and place,	and due to the o	ause(s) and manr	ner as stated.
	he Ho in 24 t he Fu pletet	Medical	(Check only 2 Medi	cal Examiner: Or an	n the basis of d manner stat	examination and/or ed.	investigation, in my o	pinion, death occur	red at the time, d	ate and place, and	d due to the cause(s)
	vith To t	Σ	29b. Signature and title of cer	tifier	0/9		29c. Licens	e number	2	9d. Date signed (i	Month, Day, Year)
	10		1m	20 //	/REL	MD		D0003792		July 2	2, 2008
-			<ol> <li>Name and address of per-</li> <li>Ernest Oser, I</li> </ol>					lver Sprine	. Marvlane	1 20910	
	Sta	te	Ernest Oser, 31. Date filed (Month, Day, Yo	7 2008	32. Registrar	's Signature	Angels 8	SPIING	,,,		
	Registr	ar	JUL (	1 2000	J- CARLO	and the see	A CONTRACTOR OF THE PARTY OF TH				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician  $A^{M}$ 2008 Mosier Gloria July 1, 7:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 17404 Redland Road Montgomery Derwood If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 23, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1□M 2🏞F 217-30-1041 73 1935 Alabama Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r than "natural", or items 23a or 28a-f sho 1 ☐Yes 2 ☑ No Directo Maryland| Montgomery Derwood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20855 17404 Redland Road United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: <u>ک</u> 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Paralegal</u> Law Firm other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) f Health and Mental F tem 27 is marked oth other traumatic even Be Hodges Anne Ferrell Unknown ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Husband) 17404 Redland Road, Derwood, MD 20855 Norman E. Mosier Department of Health Important: If item 27 any injury or other troops. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, cramatory or other place)
Metropolitan Date 20a. Method of Disposition → □ Removal from State July 1, 1 ☐ Burial 2 🙀 Cremation 4 □ Donation 5 □ Other (Specify) 2008 Alexandria, Virginia Crematory 22. Name and Address of Facility DeVol Funeral Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or pear tailore. List only one cause on each line.

Immediate dailse (Final disease or donotition resulting in death)

a. Chronic Obstructive D.11 21. Signature of Funeral Service Li 10 E. Deer Park Drive, Gaithersburg, MD 20877 Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of)

Tobacco Use Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Hypertension, Hyperlipidemia, Osteopenia, 1 X Yes 2 No 3 Probably 4 Unknown Completed Hypothyroidism, Thrombocytopathy, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate I Tricuspid insufficiency 1 ☐Yes 2 ☐No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No Certification: To 27. Manner of Death 28d. Describe how injury occurred

Division of Vital Records, P.O. After this certification funeral director, p al or Attendin s after death. Il Director: Af filled in by To the Hospital within 24 hours a To the Funeral C completely filled Hospital

28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1X Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

29b. Signature and title of certifier

(Check only one)

D0059844

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

ramanian

Asha Parvati Subramanian, M.D., 15825 Shady Grove Road, #140, Rockville, MD 20850

State Registrar

Medical

			1 _ State	State of Maryla		artment of l artificate of		Mental Hy	_	2008	22	505	
			Registrar  1. Decedent's Name (First, Middle, La	ast)		- Inoute of	Deam	2. Date of De			3. Time of	606 f Death	
	Physici /Medic		MCCampitage ir					Month July	Day	Year 208	5:15	М	
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea						4c. C	ounty of Death		P	
a self			Kensington Nursi				nsington   If Under 24 Hr			ontgome		- Frank	
	Funeral Director		578-22-6368	Sex 7. Age (In yrs	s, last birthday Yrs.	Months Days	Hours Mir		ay, Year)	Coui	olace (State on ington		
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or L	ocation				1	0d. Inside C	ity Limits	
	Mary Ind	ţoţ	Maryland Mo	ntgomery	Gaithe	ersburg					1 ☐ Yes	2 <b>%</b> No	
	or 28g	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cour	ntry?		
	s 23a		879 Clopper Ro			20878			USA				
J36	72 hours after death with the Maryland "natural", or items 23a or 28a-f show cleal Evanther must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces?  1 [XYes 2 ] No If Yes, Give Year or Dates: WW]		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No		(Specify Yes or No erto Rican, etc.)		Race - Americ Black, White, Specify: Wh			
215-0036	E . E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation	16a. Deci	edent's Usual Occup e kind of work done DO NOT use retire	oation during most of we d)	orking	16b. Kind	d of Business/In	dustry		
7	be filed with ntal Hygiene of other tha event, the	Con		4	Manu	facturing				rmaceut	ical		
משב		Be	17. Father's Name (First, Middle, Last John Francis Mc					ame (First, Middle		urname)			
Š	2 should be and Menta is marked is marked raumatic ev	은	19a. Informant's Name/Relationship			ing Address (Street		a Hutchi		Town State Zir	Code)		
<u>8</u>	12 # Z		Rosemary McCambr	, ,,	TOD. IVIAII	-	trick He			rlingto		22205	
more,			20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	Removal from State	cemetery, cre	osition (Name of ematory or other pla	•	Date July 7 2008		ation - City or To			
раппр	permit, Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	Me	F	itan Crer 2. Name and Addre rancis J	ss of Facility Collin	s Funera	1 Hom				
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	pplications that caused the dea		00 Univer				Spring	Approximat Interval Bet		
	Physician		Immediate Cause (Final disease or condition	a. Pneumonia							Onset and	Death	
	/Medical Examiner		resulting in death)	Due to (or as a conse							J. Unix	.1	
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of):					_			
	cuted and ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Uause to insease or injury that initiated events	6									
Š,	oe exe cian ar urial-t		resulting in death) Last	Due to (or as a conse	equence of):								
00/00	ficate be executed j physician and s the burial-transit	edical		<b>d</b>									
O. DOX	to the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 9 □ Unknown						23	3d. Date of delivery Month Day Year		Year	
ŗ.	that the			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of de		
ecorus,	equires sen sign ould be	ted by	Dementia, Poor I	ntake, Failure	e to Th	rive,		10	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unkno				
oec	The law rate has be page 2 sh	Completed	Deep Vein Thromb	osis				24a. Was - auto perfo 1 □ Yes	psy ormed?	24b. Were auto prior to co death? 1 □ Yes	mpletion of o	available cause of	
<u> </u>	Ician: Pertific Pector,	Be (	25. Was case referred to medical examiner?	Mooritali		0.11		eath (Check only					
5 1	ding Phys After this of funeral dir	ion: To	1 ☐ Yes 2 ☑ No  27. Manner of Death  ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	Hospital: 1 ☐ Inpatient 2 ☐  28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	of 28c. Inju	4& Nursing	Home 5 Resi			fy)		
	after deat after deat Director: d in by the	ertification: T	2 Accident Investigation 3 Suicide 6 Could not be determined	e 200 Place of Injury At I	home, farm, st cify)		1163 2	28f. Location ( City or To	Street and wn, State)	Number or Run	al Route Nun	nber,	
:	e Hospita 124 hours e Funeral letely fille	Medical C	29a. Certifier 1 ☐ Certifying PI  (Check only one) 2 ☐ Medical Exam	hysician: To the best of my kr miner: On the basis of examir and manner stated.	nowledge, dea nation and/or i	th occurred at the ti nvestigation, in my o	me, date and pla- opinion, death oc	ce, and due to the curred at the time,	cause(s) a date and p	and manner as solace, and due to	stated. o the cause(s	s)	
1	vithir To th comp	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date	signed (Month,	Day, Year)		
	241		> Chowdl	ny		Г	004312			July 7,	2008		
	V'		30. Name and address of person who Nurul Chowdhury	, MD 15216 I	Dino Dr	ive, Burt	onsville	e, MD 20	866				
	Sta Registra		31. Date filed (Month, Day, Year)	32. gistrar's Sign	nature.	model							

State of Maryland / Department of Health and Mental Hygiene 23607 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2008 **Physician** Month Khadiga Hussein Mustafa July 6, 10:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Casey House Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Months Days Hours Min. 54 578-76-3347 10, Director Egypt May Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Modical Examinar must be portified at Director 1 XYes 2 □ No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 7213 Marbury Court U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) A 27 is marked other than "r r traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hussein Mustafa Samia El Serafi ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hassan Mustafa/Brother 20817 7213 Marbury Ct., Bethesda, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 National Mem.Park Falls Church, Virginia 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 2222 Wisconsin Ave., N.W. Wash.D.C.20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ó in the past 12 months? 1 ☐ Yes 2 🛣 No Month Yea Day 5 ☐ Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed this certificate 1 □Yes 2 X No 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4□ Nursing Home 5□ Residence 6 全Other (Specify) Hospice 1 ∐Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🔀 Natural 2 Accident 1 ☐ Yes 2 ☐ No after death filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) To the I within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064615 8 no July 7, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Wroblewski,M.D. 6001 Muncaster Mill Rd. Rockville,Md. 20855 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 0 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 0 0 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Janice Emily Elvina Minnick Ju1y2008 5:00 A<sup>M</sup> /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Talbot Hospice House Easton nder 1 Year | If Under 24 Hrs. <u>Talbot</u> Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 🙀 M 2 🗆 F Months Days Hours Min Director 79 <u>212-26-3361</u> 23. 1928 Kansas Nov. Usual Residence of Decedent a or 28a-f show the notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 2☐No Director Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b 95 Park Lane 21601 United States of America Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ₩Widowed 4 Divorced Year or Dates: Caucasian is marked other than "natur aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Practical Nursing Assistant Physicians 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental ပ Clifton Ezra Holland Clara <u>Huggerth</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Deborah Renshaw 29379 Hawkes Hill Road, Easton, Maryland 21601 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD Eastern Shore Pages 1 Date 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/16/2008 4 ☐Donation 5 ☐ Other (Specify) Hurlock, Maryland Veterans 22. Name and A russ of Facility 21. Si Jure Funeral Service Licen Moore Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate

Approximate Immediate Cause (Final **Physician** enceph disease or condition resulting in death) patic /Medical Due to (or as a consequence of): **Examiner** Alolmmine Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached the 9☐ Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. 2 pe 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence & Other (Specify) Hospital Hospice al or Attending Physis after death. P 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

within 24 hours a To the Funeral L Hospital To the

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Allen

8579 Commerce Drive, Suite 106, Easton, Maryland 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature

wil

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

2008

08-05209 John McDonald

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month D. July 6, 2008 Yea 2100 hrs Medical Examiner MacDONALD JOHN R. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Mount Rainier 4105 31st Street 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Director Country) NEW YORK MARCH 5,1952 1 X M 2 F 56 Yrs 108-44-6192 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 XYes 2 No 28a-f shov MT. RAINIER notified at once. PRINCE GEORGES 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4105 31st ST. 20712 U.S.A. 23a 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S must be White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 X Married 1 Never Married Yes 5 Divorced If Yes, Give Year Yes 2 X No specify: Specify: WHITE 3 Widowed event, the Medical Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 hours Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) THEATRE DIRECTOR THEATRE 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) McDONALD MD 2121 Pages 1 and 2 should be finent of Health and Mental ELIZABETH MacDONALD JOHNR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 is m ST. MT. RAINIER MD. ANN N. MacDONALD/WIFE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Baltimore, crematory or other place) ment of H tant: If it or other Burial 2 X Cremation 3 Removal from State CHAMBERS CREMATORY 7-9-2008 RIVERDALE, MD. Donation 5 Other Specify Name and Address of Facility HAMBERS FUNERAL HOME 801 CLEVELAND AVE., I 21. Signature of Funeral Service Licensee E & CREMATORIUM, P.A. RIVERDALE, MD. 20737 M00091 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line M. dical Death a Multiple Injuries Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy has performed? death? ✓ Yes Yes 2 No 2 No this certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical æ Other<sub>4</sub> Hospital: 1 examiner? Nursing Home 5 Residence 6 Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 Yes ۵ 28d. Describe how injury occurred 28a. Date of Injury FOUND: 28c. Injury at Work? 27. Manner of Death 28b Time of Injury Certification: Fall down stairs FOUND: Natural Yes 2 🗸 No Pending 2050 hrs Jul 6, 2008 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) 4105 31st Street, Mount Rainier, MD Suicide determined (Specify) Single Family Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 O.C.M.E. July 7, 2008 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 31. Date filed (Month, Day, Year) 32. gistrar's Signatu State 2008 Registra

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			1 _ For State		State of Maryla	and / Dep	artment of F	Health and N	Mental Hy	giene,	2008	23610
			Registrar  1. Decedent's Name (First, Mi				i liiicale Ui	Dealli	2. Date of Dea			3. Time of Death
	Physici /Medio		Mary Ca	rmel.	ita Mills	5			July 5	Day	008 Year	4:15p M
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	Funeral Director		213-01-7290	1□	M 2√F	Yrs.	Months Days	Hours Min.	8 / 1 3 / 1	y, Year)	MD	nplace (State or Foreign untry)
	pun w		Usual Residence of Decedent 10a. State 10b. Cou		93	City, Town or L			10/13/1	914		
	Maryla f sho	rot		,								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r 28a	Director	MD Ca 10e. Street and Number	arrol	<u> </u>	Hamps	10f. Zip Code			10g. Citiz	en of What Cou	
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	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Midral Evri, the installed and event, the Midral Evri, the installed and the months of the Midral Evri, the installed and the months of the Midral Evri, the installed and the months of the Midral Evri, the installed and the months of the Midral Evri, the installed and the Midral Evri, the installed and the Midral Evri, the installed and the Midral Evri of	Funeral	11. Marital Status 1 □ Never Married 2 □ N		2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	1	4. Race - Amer Black, White	
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<u>Ja</u>	should be and Mental s marked o	To B	Joseph Ober	:le				Anna K	Knoer			
Maryland 2121	2 s lar is	4 9	19a. Informant's Name/Relatio		,	19b. Maili	ng Address (Street	and Number or Run	al Route Numbe	er, City or	Town, State, Z	ip Code) 21074 npstead: MI
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Baltimore,	tment of tant: If ite		1 ☐ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other	n 3 □ Rer			osition (Name of matory or other place	i			•	own, state
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4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a.		oime	113 d	lsear	0			Onset and Board
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	ed sit	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	1 "	Due to (or as a conse	quarice of):						
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ŏ n	tending Physician: The law requires that the death cer leath.  Jean,  Je	Physician/N	23b. Was decedent pregnant in the past 12 months?	230	c. If yes, outcome of preg 1 Live birth 2 Fe	tal déath 3	Ectopic pregnancy	y		23	3d. Date of deliv	very Day Year
j.	the de	ysic	1 □ Yes 2 □ No 9 □ Unknown		4 ☐ Pregnant at time of 9 ☐ Unknown	death 5L	Other (specify)	-			Monar	Day Tour
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5	ysicla s certi	o Be	25. Was case referred to medie examiner? 1 ☐ Yes 2 🛣 No		spital: 1 Inpatient 2[	T ER/Outpaties	ot 3 🗆 DOA Othe	26. Place of Death				
	ng Ph fter thi	$\vdash$	27. Manner of Death	dina	28a. Date of Injury (Month, Day, Year)	28b. Time o		Y at Nursing Hor	28d. Describe h			ny)
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<u> </u>	or At after of Direct Lin by	Certification:		rmined	28e. Place of Injury - At I building, etc. (Spec	home, farm, str cify)	eet, factory, office	1	28f. Location (S City or Tow	treet and n, State)	Number or Run	al Route Number,
	spital hours ineral y filled		29a. Certifier	ying Physic	ian: To the best of my kr	nowledge, deat	h occurred at the tin	ne, date and place,	and due to the	ause(s) a	and manner as	stated.
:	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a	Medical	one)	al Examine	r: On the basis of examinand manner stated.	nation and/or in	vestigation, in my o	pinion, death occurr	ed at the time, o	late and p	place, and due t	to the cause(s)
		2	29b. Signature and title of certi		ra, mo		29c. License		- 2	9d. Date	signed (Month,	Day, Year)
)	WIL		30. Name and address of person			um 23a) /Time	Print)	51705		( -	i C	0
			m. PANSURI			/ W/W	DR,	notesm	inste	1	UD &	112)
	Stat		31. Date filed (Month, Day, Yea		32. Registrar's Sign							
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State of Maryland / Department of Health and Mental Hygiene ?

Certificate of Death

Physician
/Medical
Examiner

For State Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2008 JULY Month SANDRA JEAN McHUGH 04 12:30AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign
Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 M 2 J 66 Yrs. Director 216 40 8807 WASHINGTON D.C JUNE 05,1942 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral [ 1213 PLATEAU PLACE 21409 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No þ Specify: Specify: WHITE 3 ☐ Widowed 4 🎇 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER ANNE ARUNDEL COUNTY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be A. FRANKLIN BOWERS ည ALMA SHUMAKER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCINE M. PORTER (DAUGHTER) 584 STOCKETTS RUN ROAD DAVIDSONVILLE, MD. 21035 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State KALAS CREMATORY 07-06-2008 EDGEWATER, MD. 21. Signature of Funeral Service L 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037 23a. Part 1. Enter the Isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of): Examiner hicilin 5. unitelly list and lines if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cow diam 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 🗆 No 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 **DK** 1. Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Mann Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 atural Injury neral Director: / 2 Accident 1 □Yes 2 □No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Funeral Empletely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I dignature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 68 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

40MMS

0 7 2008

31. Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 РΜ MacMichael 3:50 Janet Marie July 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Broadmore Assisted Living Hagerstown Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours 85 Sept. 23, 1922Maryland 219-12-1971 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1175 Professional Ct. 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Aircraft Manufacturing Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Milford Smallwood Ada Margaret French 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith MacMichael / Son 126 Shannon Ave Mt. Jackson Virginia 22842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 7/12/2008 Hagerstown, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Lie 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 4 acro Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

**Physician** 

Examiner

10a. State

**Funeral** 

Director

la or 28a-f show t be notified at

7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must b

Hygiene.

permit. Pages 1 and 2 should be filed wire Department of Health and Mental Hygien. Important: If item 27 is marked other that any injury or other traumating.

filed within 72 hours after death with the

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be ၉

/Medical

burial

Examine

Physician/Medical

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Be Completed

Certification: To

Medical

and physician attending p the by signed b has page 2 certificate I funeral director this ithin 24 hours after death.

b the Funeral Director: A

mpletely filled in by the fu

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		opic pregnancy ner (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underl	ying cause given in Part I.		o use contribute to the cause of death? 2☑No 3☐ Probably 4 ☐Unknown
			24a. Was an autopsy performed	
25. Was case referred to medical		26. Place of Deat	h (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	Other		6 Sther (Specify) Bruckmore
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	njury occurred
3 Suicide 6 Could not b 4 Homicide determined		factory, office	28f. Location (Street City or Town, St	a <i>nd Number</i> or Rural Route Number, ate)
29a. Certifier 1 Certifying Pr (Check only one) 1 Medical Exam	nysician: To the best of my knowledge, death occ miner: On the basis of examination and/or investi and manner stated.	curred at the time, date and place, gation, in my opinion, death occur	and due to the cause rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)

154-2

State

completely

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31. Date filed (Month Registrar

hael



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

relical Campus Hazerstown MO

		1 - For State Registrar	State of M	aryland 	/ Depa	tificate of	lealth and Death	Mental Hy	/gier Reg. N		23613
Physicia /Medic		1. Decedent's Name (First, Middle, I Thanh T. Nguyen						2. Date of D  Month  July		Day Year 2008	3. Time of Death 6:15 A. M
Examin		4a. Facility Name (If not institution, g 15614 Thistlebri				4b. City, Town, o	r Location of Dear	th		tc. County of Dear	h
Funeral Director		5. Social Security Number 6. 213-11-7214  Usual Residence of Decedent	Sex 7. Ag 1 □ M 2 🗓 F	92	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		av. Yea	ar) Co	hplace (State or Foreign untry) tnam
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or items 23a or 28e-f show any injury or other treumatic sysnit, it is Medical Examinar must be routiled at once.	Director	10a. State 10b. County  Maryland Montgom  10e. Street and Number	ery		Town or Loo						10d. Inside City Limits 1 ☐ Yes 2 X No
s 23a or	ral Dir	15614 Thistlebri				10f. Zip Code 20853			Vie	citizen of What Co tnam	
036 ours after de rel', or Itam	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cuba ☐ Yes 2X No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	0-	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. 7 is marked other then "naturel", or treumetic svent, the Mudicul Exem	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or s	5+)	(Give I life. D	ent's Usual Occup tind of work done of O NOT use retired	during most of wo	rking		Kind of Business	
and 2 d be filed v antal Hygie tad other t	Be	12 17. Father's Name (First, Middle, Last Chi V. Nguyen	51)	1	Home 1	Maker		me (First, Middle	-	n Home	
Maryl nd 2 shoule lith and Me 27 is mark r treumati	ပ	19a. Informant's Name/Relationship Son H. Truong, So			15614	Address (Street of Thistlet	oridge Di	ural Route Numb	oer, City	or Town, State, 2	Tip Code)
Baltimore, bermit. Pages 1 ar Department of Hea Importent: If item: any injury or other		20a. Method of Disposition  1 XBurial 2 Cremation 3  4 Donation 5 Other (Special Control of Control	Removal from State	20b. Plac	e of Dispos etery, crem	ition (Name of atory or other place	Jul	Date y 12,		Location - City or	
Balti permit. Departin Importe any inju		21. Signature of Funeral Service Lice  Burn M		101508	22.	Name and Address	ss of Facility			e VA 2203	
Pnysician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. CHOLANG Due to (or as	GIO CAN a consequent COBSTE	Do not ente RCINON ice of): RUCTI(	r the mode of dyin	g, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death
cate be cate be physicial the burn	edical Examiner	fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as  d.		,						
law requires that the death certificate been signed by the attending 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	ath 3□E	Ectopic pregnancy Other (specify)				23d. Date of del Month	very Day Year
S e g	2	Part II. Other significant conditions HYPERTENSION	contributing to death b	ut not resultin	ig in the und	derlying cause give	en in Part I.				the cause of death?
The ate h	Completed							24a. Was auto perfo 1 🗆 Yes	psy ormed?	prior to death?	topsy findings available completion of cause of
Sicie Sicie	0	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 □ Inpatie	nt 2□ER/	/Outpatient	3□ DOA Othe	26. Place of Dea			6 □Other (Spec	rifu)
E 6 19 1	6	27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigatic 3 □ Suicide 6 □ Could not l	28a. Date of Injui (Month, Day	y Year) 28	b. Time of Injury	28c. Injury Work	at :? /es 2 \sum No	28d. Describe			,
tal or A safter set Direct of in by	Certificati	4 Homicide determined	building, etc	c. (Specify)		,		City or To	wn, Sta	te)	ral Route Number,
in 24 ho he Fune pletely f	edical	29a. Certifier 1	hysician: To the best of miner: On the basis of and manner sta	examination	dge, death and/or inve	occurred at the timestigation, in my op	e, date and place pinion, death occu	, and due to the irred at the time,	cause( date ar	s) and manner as nd place, and due	stated. to the cause(s)
V Vith		29b. Signature and title of certifier	Yun	_		29c. License				Y 7, 2008	
		30. Name and address of person who TON THAT CHIEU, 31. Date filed (Month, Day, Year)	M.D., 7505	NEW H	AMPSH	•	UE, SUIT				
State Registra DHMH 17 Rev 1/200	ŧ	JUL 0 8 20		r's Signature	Los	E)	120.50				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	e of Marylan		artment of F rtificate of .		Mental Hy	giene	กกล	23614
F	44.5		Decedent's Name (First, Middle, Last)			imouto or	Doutri	2. Date of De	ath		3. Time of Death
	Physici /Medio		Michael Anthony Nardo					July	O1	2008	03:45 P M
	Examin	er	4a. Facility Name (If not institution, give street and				r Location of Deat	h		inty of Death	_
	Funeral		Mandrin Chesapeake Hospice  5. Social Security Number 6. Sex	7. Age (In yrs. I	last birthday)	Harwood If Under 1 Year	If Under 24 Hrs		th	e Arund	
b	Director		060-24-0227 <sup>1∆M 2□</sup>	<sup>] F</sup> 77	Yrs.	Months Days	Hours Min.	10/18/	y, Year) 1930	Penn:	lace (State or Foreign try) Sylvania
	and ww		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10	0d. Inside City Limits
	with the Marylan a or 28a-f show the notified at	ţō	Maryland Anne Arundel	An	napoli	S					1 ☐ Yes 2 No
	th the or 28a e noti	)irec	10e. Street and Number		паротт	10f. Zip Code			10g. Cîtizen	of What Coun	try?
	ath wi	ral	904 Perry Landing Cour			21401				d State	
30	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	by Funeral Director	1 Never Married 2 Married	Decedent Ever in U. ed Forces? Yes 2 No s, Give or Dates: 1950		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2X No	lispanic Orlgin? (S an, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)		Race - America Black, White, e	etc.
15-0036	2 hour atural cal Ex	ted b	15. Decedent's Education		16a. Deced	lent's Usual Occup	ation			ecify:White	
212	be filed within 72 hatal Hygiene. d other than "natu event, the Medical	Completed	(Specify only highest grade comple	eted) ege (1-4or 5+)	(Give life. L	kind of work done of NOT use retired	during most of wo	rking			
7	filed v Hygie other t		17. Father's Name (First, Middle, Last)		Press	man	18. Mother's Nar	ne (First, Middle,			nting Office
land	uld be Aental rked o tic eve	То Ве	Anthony Nardozzi				Theresa			,	
lar)	ges 1 and 2 should t of Health and Men If Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type. Print)			g Address (Street	and Number or Ri	ural Route Numb			
e, e	s 1 and of Health item 27 other tr		Rose-Marie A. Nardozzi			erry Land	ling Cour	rt, Anna		MD 214	
DE L	Pages nent of I int: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal for 4 ☐ Donation 5 ☐ Other (Specify)	from State	as Crei	natory or other plac	i			•	
Saltimor	permit. Pages Department of Important: If i any Injury or o	ĺ	21. Signature Fuyeral Say to icensee	Kar	22	. Name and Addres	ss of Facility Ge	orge P.	Kalas	Funera	Maryland al Home
۵_	<b>8 9 7</b> 6 8		1-10/WA		29	73 Solomo	ons Islan	d Road,	Edgewa	ater, M	ID 21037
			28a. Part1. Inter the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final	nat caused the death on each line.	n. Do not ente		3	or respiratory a	rrest,		Approximate Interval Between Onset and Death
-	Physician /Medical		disease or condition resulting in death)	e to (or as a consequ	etast	n C	ner			_	
	Examiner			Ren	1100	elapin	Lyn	vako	mer.		
-	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e to (or as a consequ	ien e of):	/		/			
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Š	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	s, outcome pf pregna ive birth 2□Fetal Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)				Date of deliver Month	ry Day Year
į	t the d by the ached	hysi		Jnknown	,au						
, J	res tha signed I be det	þ	Part II. Other significant conditions contributing	to death but not resu	lting in the un	derlying cause give	en in Part I.				e cause of death?
, COLON	v requi	Completed						1 🗆 \			ably 4 □Unknown
ב ב	he lav e has age 2 :	duc						24a. Was autop perfo		lb. Were autop prior to com death?	osy findings available apletion of cause of
ō	ian: Trifficat	Be	25. Was case referred to medical				26. Place of Dea	1  Yes ath (Check only o	22No		2 □ No
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5	ding F	ö	1 → atural 5 □ Pending (/	Date of Injury Month, Day Year)	28b. Time of Injury	28c, Injury Work M 1 🗆		28d. Describe h	ow injury occ	curred	
2	Atten	ficat	3 Suicide 6 Could not be determined 28e. P.	Place of injury - At hor	me, farm, stre		Yes 2 ☐ No	28f. Location (S	Street and Nu	mber or Rural	Route Number,
5	ttal or rs after ral Dire	Certification:	T- Tronicae	uilding, etc. (Specify			10	City or Tow	ın, State)		
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	edical	29a. Certifier 1 Certifying Physician: To (Check only one) 1 Medical Examiner: On the and n	o the best of my know he basis of examinati manner stated.	vledge, death ion and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	e, and due to the erred at the time,	cause(s) and date and plac	manner as sta ce, and due to	ated. the cause(s)
	To the To the comple	Me	29b. Signature and title of certifier	-		29c. License	number	.	29d. Date sig	jnejd (Month, E	Day, Year)
. 4	UALK	7	· Cut Ha	n.	MB	0	533,	26	7/	1/05	
1	S CON		30. Name and address of person who completed of	cause of death (Item	23a) (Type, F	Print)	RAC	10 000	) A.	2011	s mongo
	Stat	е	31. Date filed (Month, Day, Year)	2. Pigistrar's Signat	ure	156/18	5,	C 300	ITA	10/011	5 MOHYO
	Registra		1111 0 7 2008	AL.	4 1						

State of Maryland / Department of Health and Mental Hygiene 23615 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** July 2, Dorothy Coleman Popkin 2008 8:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1801 East Jefferson Street #531 Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Months Oct. 8, Poland **Director** 052-12-5882 87 1920 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1801 East Jefferson Street #531 20852 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite may Injury or other traumatic event, the Medical Examina ance. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 V No Specify ş Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager 10 Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Calvin Coleman ပ္ Eva Kaplan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josh Popkin - Son 505 Campbell Road Keswick, VA 22947 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beth Moses Cemetery 7/4/2008 Farmingdale, New York 21. Signature of Funeral Service License Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic carotid gland cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buris Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery signed by the atter 3 Ectopic pregnancy In the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) □Yes 2⊠No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Diabetes Mellitus II 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No Decubitus Ulcer - Sacrum 24a. Was an autopsy Hypertension 1 ☐ Yes 2 🖾 No OckorHy tification: To Be C filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours atter deatl To the Funeral Director: 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1801 East Jefferson Street Rockville, MD 20852 Zeba Shaheen Geloo, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 23616 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** John Eugene Pelphrey /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 05 20 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months 1X M 2□ F Days Hours 235-62-9417 68 Director Feb 23 1940 Kentucky Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1X Yes 2 No Directo Caroline Maryland Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25936 Fox Grape Road 21639 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🛣 No White Specify: þ 3 X Widowed 4 ☐ Divorced Completed epartment of Health and Mental Hygiene. mportant: If Item 27 Is marked other than "naturny in ury or other traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) County Roads Inspector 12 Caroline County Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sherman Pelphrey Emma Blanton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Hartman/ friend 159 Steele Road; Waterloo, New York 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Dunial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery 07/19/08 Greensboro, Maryland ermit 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 515 **Physician** /Medical Due to (or as a o nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Status-post cystectomy attending physician and for use as the burial-transit Exami 51a Box 68760, certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.O. 1 Yes 2 No the detached 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the upderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an )/Sleepe with old Myocardal performed?

26 Place 12 page 2 s has Theroscherotic certificate oronary neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Tyes 2 No Other: မ 1 🖬 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) or Attending 1 Natural 5 ☐ Pending investigation death. 1 🗌 Yes 2 □ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural-Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 66 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Muchae

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		4	For State Registrar	State of Ma	ryland	•		f Health a			giene 00	8 23617
	Physicia	_	1. Decedent's Name (First, Middle, Las  1. Decedent's Name (First, Middle, Las  1. Decedent's Name (First, Middle, Las		Pena	1				2. Date of Dea Month	ath Day Ye	3. Time of Death
	/Medic Examin	-	4a. Facility Name (If not institution, give Corrett County M		Hosa	1	4b. City, Tov	m, or Location of	of Death	land	4c. County of	
	Funeral Director		5. Social Security Number / 6. Se	9x 7. Age KDM 2□F	i (In yrs. las 85	t birthday) Yrs.	If Under 1 Y Months D	ear if Under ays Hours	24 Hrs./ Min.	8. Date of Birt (Month, Da) 4/26/	h y, Year) 1923	Birthplace (State or Foreign Country) Maryland
	aryland ahow dat		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo		land				10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	r 28a-f	Director	MD Garr  10e. Street and Number	ell			10f. Zip Co				10g. Citizen of Wha	at Country?
	ath with	raiD	2579 Hutton Road					2155				USA
39	urs after dee al', or items	by Fur	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 XYes 2 ☐ h If Yes, Give Year or Dates:	wWII ™Kore	a	Was Decedent f Yes, specify 1 ☐ Yes 2X	of Hispanic Ori Cuban, Mexical No Specify:		ecify Yes or No Rican, etc.)	Specify:	American Indian, White, etc. White
Maryland 21215-0036	permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "natural", or items 23a or 28a-f show simportant: if Item 27 is marked other then "natural", or items 23a or 28a-f show any hujury or other treumatic event, the Medical Examinar must be notified at ance.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation		16a. Deced (Give life. I	dent's Usual O kind of work o DO NOT use r litary	one during mos	st of worki	ng	16b. Kind of Busin	.S. Army
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Mary	id 2 should th and Mer 27 le marke treumatic		19a. Informant's Name/Relationship (								ar, City or Town, Staryland	ate, Zip Code) 21550
Baltimore,	Peges 1 end nent of Health int: If Item 27 iry or other to		20a. Method of Disposition  1 \ Burial 2 \ Cremation 3 \ 4 \ Donation 5 \ Other (Specification 1)	Removal from State	сел	netery, crer	sition (Name inatory or other	r place)	7/11	) (08	20c. Location - Ci	
Baltin	permit. P Departme Importen any Injur.		21. Signature of Funeral Service Liver			22	2. Name and A	Funera	ity	32	S. Secon kland, MD	d St.
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8760,	cate be executed obysician and the burial-transit	cal	resulting in death) Last	Due to (or as	a conseque	ence of):						
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ds, P	uires that signed b Id be deta	Ď	Part II. Other significant conditions of	contributing to death b	out not result	ting in the u	nderlying caus	se given in Part	1.	23e. Did 1	1 2	ute to the cause of death?  Probably 4  Unknown
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Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other		h (Check only		
on of	S =	tion: To	1 Yes 2 Ao  27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Inju		R/Outpaties 28b. Time of Injury		Injury at Work?			dence 6 □Other how injury occurred	
Division of	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of In	jury - At hom ic. (Specify)	ne, farm, st	reet, factory, o	ffice			(Street and Number wn, State)	or Rural Route Number,
	• Hospite 24 hours • Funerel etely filled	edical C	29a. Certifier (Check only one) Certifying Pt (Check only one)	nysician: To the best miner: On the basis of and manner st	f examination	ledge, deat on and/or in	th occurred at evestigation, in	the time, date a my opinion, de	and place, sath occur	and due to the red at the time,	cause(s) and mani date and place, an	ner as stated. Indicate the discourse of the discourse of the cause of the cause of the cause of the discourse of the discour
	To th within To th comp	Me	29b. Signature and title of certifier				29c. l	icense number			29d. Date signed	(Month, Day, Year)
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	VA 1+	10	30. Name and address of person who Dr. Donald Richte					e, 0akl	and.	Marvla	nd 21550	)
	St: Regist		31. Date filed (Month, Day, Year)		rar's Signatu	ıre	Sports.	, , , , , , , , , , , , , , , , , , , ,	,	<u>-, ,</u>		

08-05347 Teressa Marie Pel	Itie				Ink. Ensure All Co of Health and Men		ble. 200	8 2361
		- For State Registrar		Certificate of	of Death	Reg		0 2001
Physician Medical Examine	n/ er	1. Decedent's Name (First, Middle,La: TERESSA M	ARIE PEL	TIER		2. Date of Death Month L July 12, 200	Day Year 08	3. Time of Death 1237 hrs
tr.		4a. Facility Name (if not institution, git Carroll Hospital Center	ve street and number)		4b. City, Town, or Location Westminster		4c. County of Death Carroll	
Funeral Director		-7121100	Sex 7. Age (In	n yrs. last birthday) 39 Y	If Under 1 Year If Under 1 Year Months Days Hours		Foreig	hpiace (State or n untry) WV
nd chow any		Usual Residence of Decedent  10a. State 10b. County  ARI	2011	c. City, Town or Loca SYKE	SVILLE			10d. Inside City Limits 1 Yes 2 No
the Marylar as or 28a-f s	2 5	10e. Street and Number	nama l	20ad	10f. Zip Code 217-8	109	Citizen of What Cour	ntry?
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  The strength of the Maryland ment of the strength of the	Funerai	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 Yes 2	If	/as Decedent of Hispanic Ori Yes, specify Cuban, Mexican	n, Puerto Rican, etc.)	14. Race - Americ White, etc.	can Indian, Black,
natural",	ᆰ	15. Decedent's Education (Specify of	d If Yes, Give Year or Dates: only highest grade comple		Yes 2 No specify ent's Usual Occupation (Give most of working life. DO NOT	kind of work done	Specify: UU 16b. Kind of Business/I	ndustry
vithin 72 F ene. er than "r Medical E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		Lome make	er.	own 1	nome
1215-0036 be filed within 7 mtal Hygiene. rrked other than vent, the Medica	8 E	17. Father's Name (First, Middle, Las	Heldret	h		r's Name (First, Middle, Ma WARLENG	= DAVI	
MD 21 d 2 should th and Mer n 27 is mar		19a. Informant's Name/Relationship ( CURT 15 Pe/Fi	Type, Print) CR/Hysba	no 5/7		Road Sykes	svilleme	121784
Baltimore, ermit. Pages 1 and Department of Heal Important: If iten njury or other tra		20a. Method of Disposition  1 Burial 2 Cremation 3			osition (Name of cemetery, other place)	7/13/2008	20c. Location - City or WINFIE	
Baltimore permit. Pages 1 Department of F Important: If injury or other	İ	4 Donation 5 Other Specification of Funeral Service Lice		-	Name and Address of Facility	VIN ZUMB	MN FH an	now Co 2178 BURG-MO
Physician /Medical	- ľ	23a. Part I. Enter the disease, or comfailure. List only one cause on e	plications that caused the each line.	e death. Do not enter	the mode of dying, such as	cardiac or respiratory arres		Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	ience of):		· · · · · · · · · · · · · · · · · · ·		
		if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequ	ence of):				
T In the	цį.	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ					
0, e be executed 7 sician and burial - trans	edical	UNPENDED			g882 8/28/08	TT	Load Date of deliver	
itial Records, P.O. Box 68760, ician: The law requires that the death certificate be execute sertificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial - tran		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unknow	23c. If yes, outcome of the line of the li	2 1	Fetal death 3 Ectop Other (Specify)	ic pregnancy	23d. Date of deliven Month	y Day Year
P.C	2	Part II. Other significant conditions	contributing to death bu	ut not resulting in the	e underlying cause given in F		eacco use contribute to 2 ✓ No 3 Prot	
ital Records, P.O. Boxician: The law requires that the deald so certificate has been signed by the affector, page 2 should be detached for	Completed					24a. Was an autops perform	y prior to oned? death?	utopsy findings available completion of cause of
tal Recian: The certifical ector, par	2 8 8	25. Was case referred to medical examiner?	Hospital:		<del></del>	(Check only one)		

Division of Vita

To the Hospital or Attending Physicis within 24 hours after death.

To the Funeral Director: After this compiletely filled in by the funeral director.

Medical Certification:

2

3

Accident

Suicide

Homicide

31. Date filed (Month, Day, Year)

WIL Ø

1 ✓ Yes 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 1 X Natural

determined

Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29a. Certifier (Check only one) 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Margarita Korell MD.

111 Penn Street, Baltimore, MD 21201

28c. Injury at Work?

29c. License number

O.C.M.E.

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

July 13, 2008

29d. Date signed (Month, Day, Year)

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	c or maryland	•	rtificate of E			Reg. No. 2	08	236	20		
	Dhysisia		Decedent's Name (First, Middle, Last)					Date of Dea     Month	Day	Year	3. Time of D 9:44			
	Physicia /Medic		Esther Mari				Lucation of Dooth	July	03	<b>2008</b> y of Death	9:44	- aw		
	Examin	er	4a. Facility Name (If not institution, give street a	nd number)		4b. City, Town, or				ice Geo	roets	ĺ		
~	Francis		13129 Summer Tree Way  5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year	ure1 If Under 24 Hrs.	8. Date of Birt	th		lace (State or	Foreign		
	Funeral Director		099-22-8205 1□M 25	79	Yrs.	Months Days	Hours Min.	(Month, Da January	28, 1929	Court	Ohio			
	p ,		Usual Residence of Decedent  10a, State 10b, County	10c. City, T	own or Lo	cation				1/	Od. Inside City	Limits		
	arylar shov	5			OWIT OF EO	Lau	ma1				1 X Yes 2	²□No		
	the M	rect	Maryland Prince Georg	ge-s		10f. Zip Code	161		10g. Citizen of	What Coun	try?			
	3a or	Funeral Director	13129 Summer Tree Way				20707			U.S	.A.			
	death	ner	11. Marital Status 12. Was	Decedent Ever in U.S. ed Forces?	13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra Bla	ce - Americ ack, White, e				
ဂ္ဂ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, if a Modical Examinar must be notified at once.	by F.	1 Never Married 2 Married 1 If Ye	Yes 2 No s, Give		1 ∐Yes 2 <b>⊠</b> No	Specify:		Speci	fy: Ca	aucasian			
215-0036	hour tural	ed b	15. Decedent's Education	r or Dates:	  6a. Dece	dent's Usual Occupa	ation		16b. Kind of B	3usiness/Inc	dustry			
3	in 72 in "na Medic	Completed	(Specify only highest grade compl	eted) ege (1-4or 5+)	(Give life. I	kind of work done o DO NOT use retired	luring most of work )							
7	d with	E C		2		Secret			Seventh-I		entist C	nurch_		
yland	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	Name (First, Middle, Maiden Surname)  Matilda Gatz						
<u> </u>	nould d Men narke	은	Daniel Frederick		10h Mailir	ng Address (Street a	and Number or Ru			n. State. Zic	Code)			
Z	d 2 st th and t7 is n traur		19a. Informant's Name/Relationship (Type. Prin Ernest Runge - Husband	"		Summer Tre					ŕ			
<u>စ</u> ်	f Hea	1 3	20a. Method of Disposition		Date	20c. Location		wn, State						
Ê	Page nent o		1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)		2/2008	Brentwo	od, Mai	yland						
saitimore,	spartn spartn iporta ny inju		21. Sign whe of Funeral Service Licensee	ss of Facility <b>i Funeral</b> l	Home, Inc									
מ	20 E # 9	.// V	14 JUM 1 44	mpshire Av	enue, Sil	ver Sprii	ıg, Mar	yland 20 Approximate						
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one caus	that <b>f</b> aused the death. e on each line.	Do not en	er the mode of dyin	g, such as cardiac	or respiratory a	111651,		Onset and Do	reen		
٠,	Physician /Medical		reculting in death)	Acute Renal Fa					·		Days			
المع	Examiner			ue to (or as a consequer <b>Diabetes</b>	ice oi).									
		ner	Cognoptially list conditions	ue to (or as a consequer	nce of):									
	acuted Ind transit	Examiner	triat irilliateu everts	Coronary Arter		ase								
Ď,	tificate be executed ig physician and as the burial-transit			ue to (or as a consequer	ice oi):									
<b>6876U</b> ,	tificate ng physi as the I	/ledical	d	Hypertension										
×	n certi anding use a	n/M		es, outcome of pregnanc		☐ Ectopic pregnanc	v			Date of deliv		ear		
	w requires that the death cer been signed by the attendir should be detached for use	Physician/N	In the past 12 months?  1 ☐ Yes 2 ■ No	Pregnant at time of dea		Other (specify)	,			nortui	Day 1	541		
<u> </u>	nat the d by th letache	Phy	9 ☐ Unknown  Part II. Other significant conditions contributin	a to death but not resulti	na in the u	Inderlying cause give	en in Part I.	23e. Did	tobacco use co	ntribute to t	he cause of de	ath?		
ds,	requires that been signed b hould be deta	d by	Tartii. Ottos significant oonasaa	9		, , ,		1 🗆	Yes 2 ▼ No	3☐ Pro	bably 4 □ U	nknown		
Vital Records,	v requ	Completed						24a. Was		. Were auto	opsy findings a	ıvailable		
Š	E 8 01	duic						auto perfe 1 □ Yes	ormed?	death?	ompletion of ca 2 □ No	use of		
<u>ra</u>	siclan: The la certificate ha rector, page 2	a	25. Was case referred to medical				26. Place of Dea							
> 0	Physiclan: this certific ral director,	To B	examiner? 1 ☐ Yes 2 🗷 No Hospital	1 Inpatient 2 E			4 🗀 Nulsing II		idence 6 🗆 C		ify)			
0	iding Physician: th. After this certifications funeral director,	on:	1 X Natural 5 ☐ Pending	Date of Injury (Month, Day, Year)	8b. Time o Injury	Worl	yat k? Yes 2 ∐No	28d. Describe	how injury occi	urred				
Division	teal lear to the	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e	Place of Injury - At hom	e, farm, st		103 2 110	28f. Location	(Street and Nur	nber or Rur	al Route Numb	ber,		
≧	after after Direct	Certification:	4 ☐ Homicide determined	building, etc. (Specify)				City or 10	iwn, State)					
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	ledical C	29a. Certifier 1 ★ Certifying Physician: (Check only 2 Medical Examiner: O	n the basis of examination	edge, dea n and/or i	th occurred at the ti nvestigation, in my o	me, date and place opinion, death occu	e, and due to the erred at the time	e cause(s) and e, date and plac	manner as e, and due l	stated. to the cause(s)	+		
	To the le within 2 To the I Complet	Med	29b. Signature and title of certifier	d manner stated.		29c. Licens	e number		29d. Date sign	ned (Month,	Day, Year)			
				J Phusici	040	D	61067		July	3,20	$8 \infty$			
	10		30. Name and address of person who complete  LAURA KHANDAGUE, N  31. Date filed (Month, Day, Year) 7 2008	d cause of death (Item 2	3a) (Type,	Print)	and Side	25 S:	lver So-	ina M	aruland	20903		
	- 04	at a	31. Date filed (Month, Day, Year) 17, 2000	32. Registrar's Signatur	ret,	Ty Dulev	uie out	5 01		.,)	11			
	Sta Registi		31. Date filed (Month Pay, Year) 7 2008	Miller 1	13- 1	Service Services								

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 008 - For State Registra Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 10:15 A<sup>N</sup> July 4, 2008 Doris Virginia Reichard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Wilson Health Care Center Gaithersburg If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Mar 21, 1924 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1□M 2X F Maryland 577-24-6808 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Exercicer must be notified at 1 XYes 2 No Gaithersburg MD Montgomery Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or USA 301 Russell Avenue #319 20877 death 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No 14 Race - American Indian or items 11. Marital Status Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 Divorced 'neturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Dance Instructor Pages 1 and 2 should be filed w iment of Health and Mental Hygie tant: if item 27 is marked other ti jury or other traumatic event, to 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel Irene Bowers George Poulton Spangler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) George Spangler/nephew/executor 22 Virginia Drive Gaithersburg, MD 20877 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department or important: If eny injury or one. Chesapeake Crematory 07/08/08 Beltsville, MD 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service I 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Adult failure to Turroe **Physician** /Medical Motastatic renal cell carcinoma to lean Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 Completed by Physician/Medical the Ses IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) signed by the at the detached for 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown utinsen A Loscell 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy ide 1 ☐ Yes 2 ☐ No Prenious c 2 No 1 ☐ Yes Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending s after dec. 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 004115 14. Robert Durachler 201 RUSSELLAVEVIUR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAITHERSBURE RUS IX. ROBERT BIRSCHBARH MIN

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 0 9 2008

32. Pojistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4, 2008 10:36 July Gloria G. Raber /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cattered Living of Ocean Pines Ocean Pines Worcester Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, **Funeral** Days 1 □ M 2X F 1927 New York 063-22-6803 81 5, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State iral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√CNO Director MD Worcester Berlin 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 46 Burr Hill Dr. 21811 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□Yes XXNo Baltimore, Maryland 21215-0036 white Completed by 3 XWidowed 4 ☐ Divorced "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Monce. other than Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Regina Schoeber August Hirstius 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stephen Raber/ son 46 Burr Hill Dr., Berlin, MD<u>21811</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 □Removal from State Cape Henlopen Crem. 7/7/2008 Frankford, DE 4 □ Donation 5 □ Other (Specify) 21. Signature of uneral Service Live 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Colon CA Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number and title of certifie 29b. Signa WUO53714 cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed Franklin Ne Siete 302 Bernin MD BAIZ

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Joseph George Ruta 2008 /Medical  $\mathtt{JULY}$ 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Berlin Nursing Home Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Months Days Hours Min 076-12-4493 85 2/18/1923 NY Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 51 Teal Circle 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married ∰XYes 2 Yes, Give 1 ☐ Yes 2 No þ If Yes, Give Year or Dates: Specify Specify: white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stock Broker 12 Investment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Ruta Pasqualina Alfano ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Terrace Circle, Great Neck, NY 11021 Christopher Ruta / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cape Henlopen Crem. 7/8/2008 Frankford, DE 4 □ Donation 5 □ Other (Specify) 21. Signature i Funeral Service 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Beath Monife; Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably WUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No 1 Tyes Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred

Division or Vital Records, P.O. Box 68760,

Funeral

Director

show

"natural", or items 23a or 28a-f shov dical Examiner must be notified at

other traumatic event, the Medical

12 should be filed within 72. It and Mental Hygiene. 7 is marked other than "na

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**Physician** 

/Medical

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State Registrar

Examiner

Important: If Item 2 any injury or other once.

Health

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72 hours after

RUTA, JOSEPH Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed or Attending Physiclan: To the Hospital within 24 hours a

To the Funeral

3 Suicide 4 Homicide	6 Could not be determined	28e. Place of injury - At home, farm, streed building, etc. (Specify)	et, factory, office	28f. Location (S City or Tow	Street and Number or Rural Route Nu vn, State)	ımber,
29a. Certifier (Check only one)	Certifying Physi	er: On the best of my knowledge, death er: On the basis of examination and/or inve	occurred at the time, date and placestigation, in my opinion, death occ	e, and due to the curred at the time,	cause(s) and manner as stated. date and place, and due to the cause	⇒(s)
29b. Signature and ti	tle of certifier		29c. License number		29d. Date signed (Month, Day, Year)	
	tolle	wh wo	D2856.	9	717108	
30. Name and address	ss of person who con	npleted cause of death (Item 23a) (Type, P	rint)	_	1511	
Nellolog	Dond	uli, w 1209	Courted Hogh	un teu	ret Folial, De	19944
31. Date filed (Month	, Day, Year)	32 Registrar's Signature		1		

1 T Yes

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5 Pending

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32, Registrar's Signature

(Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Donna Sue Rollins A008 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hagerstowii

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) |
| Sep. 4,1941 Washington County Hospital Hagerstown Washington County 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Director 272-38-9755 66 Ohio Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f shore Examiner must be notified at Little Orleans 1 ☐ Yes 2 X No Director Maryland Allehany County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11815 Price Rd. NE 21766 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ ZMNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: δ 3 X Widowed 4 ☐ Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John W. Lee Mable Knapp Lee ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Rollins-son 11407 Tedrick Dr. Big Pool, MD 21711 20b. Place of Disposition (Name of cemetery, ctematory or other place)
Crownsville Veterans 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or oti
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7-14-2008 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Rome Kaitlin 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) sehsis **Physician** /Medical Due to (a as a consequence of): Examiner Ob Struct Chronic Sequentially list conditions Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir The law requires that the death certificate be executed Cene Brovasal ng physician and as the burial-tran Due to (or as a consequence of): Physician/Medical signed by the attending I IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown peen s certificate has by irector, page 2 sh 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 □Yes 2 No 1 ☐ Yes e Hospital or Attending Physician: 124 hours after death.
e Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the I 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 24 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 and manner stated.

5H-2

P.O. Box 68760,

Division of Vital Records,

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) JUL 09

29b. Signature and title of certifier

30. Name and address of person who

1ama

completed cause of death (Item 23a) (Type, Print)

29c. License number

2323

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death **Physician** 200 bynes /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner agers 8. Date of Birth (Month, Day, (In yrs. last birthday, 7. Age 5. Social Security Number **Funeral** Min. Months 1 M 2 □ F West Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XINo Hagerstown Maryland | Washington Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number be filed within 72 hours after death with U.S.A. 21740 17962 Garden Lane Apt.3 Funeral 12. Was Decedent Ever in U.S. Arrged Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Nes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 21 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Completed by white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Government law Enforcement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Wilkinson ၉ James Howard Roby Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 77 is many Injury or other 17962 Garden Lane, Apt. 3, Hagerstown, MD 21740 <u>Edna Mayetta Roby / Wife</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 07/11/2008 | Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 21. Signature of Funeral Ser 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause needs line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a co-Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and s the burlai-trans Due to (or as a consequence of): P.O. Box 68760, attending p IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) been signed by the sahould be detached 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy 2 No 2 No 1 ☐ Yes or Attending Physician: 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death, Funeral Director: A investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 💆 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 24 29d. Date signed (Month, Day, Year) 29b. Signature and litle of certified T person who completed cause of death (Item 23a) (Type, Print) 30. Name HOH 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

		•	For State Registrar	State of M	arylan		partment ertificate			ınd M		giene Reg. No	200	18	23626
	Diiii		Decedent's Name (First, Middle)	, Last)		1					2. Date of De Month	ath Da	y 1	'ear	3. Time of Death
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	Examin	er	4a. Facility Name (If not institution		bri	Via	4b. City,	lown, or	Location o	Death		40	County of	Dealli	H
	Franci		5. Social Security Number	- VIIOV -	ge (In yrs.		ay) If Under		If Under		8. Date of Bir	th Your	oa	). Birthp	lace (State or Foreign
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	deeti	ner	11. Marital Status	12. Was Decedent	Ever in U	I.S.	3. Was Deced	lent of His	spanic Orig	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Black,	Americ White,	
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yla		T <sub>o</sub>	Howard Schumann			405.14	ailing Address	(011			nkner	or City	or Town S	tate Zin	Code
Maryland	O1 00 00 00		19a. Informant's Name/Relations Glenn I. Schuma				Scener						1503		0000)
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Baltimore,	그런답금 .		21. Signature of Funeral Service		\						man Fu				
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,092	death certificate be executed  We attending physician and for use as the burial-transit	icai Examiner	shock, or healt dilure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a b. Due to (or a c. Due to (or a	s a consecus	quence of)	eroti (	_ (0	vouq	ry 1	Jas cul	lav	Lisea	ese 1	Onset and Death
687	ficate physics the			d											
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Δ.	8 <u>1</u> 9	þ	Part II. Other significant condition	ons contributing to death	but not res	sulting in th	e underlying o	ause give	en in Part I			tobacco		bute to t	he cause of death?
Records,	w requii been s should	Completed									24a. Wa	s an	24b. W	ere auto	opsy findings available
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ξ	Physician: this cartific ral director,	To B	examiner? 1 Yes 2 □ No	Hospital: 1 🗌 Inpai	ient 2	] ER/Outp	itient 3 DC	Othe	9r: 4 □ Nu	ursing Ho	me 5 Res	sidence	6 Dothe	r (Specia	<b>'y</b> )
n of	ding Ph h. After th funeral		27. Manner of Death  Natural 5 ☐ Pendir	28a. Date of In (Month, D	ury ay Year)	28b. Tin Inju		28c. Injury Work			28d. Describe	how in	ury occurre	d	
sio	Attending ir death. ector: After by the fune	cati	2 Accident investi 3 Suicide 6 Could	gation not be	aire. As h		M .		Yes 2 🗌	No	28f Location	(Street a	and Numbe	r or Run	al Route Number,
Division	를 를 들	Certification:	4 Homicide determ	28e. Pface of Inbuilding,	etc. (Speci	ify)	, street, factor	y, office			City or To				
	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifyir (Check only 25 Medical one)	ng Physician: To the bes Examiner: On the basis and manner:	of examin	owledge, o ation and/	leath occurred or investigation	at the tim	ne, date an pinion, dea	nd place, oth occur	and due to the	e cause( e, date ar	s) and man	ner as s	stated. o the cause(s)
	Within To the	Me	29b. Signature and title of certifie		20		29	c. License	number			29d. D	ate signed	(Month,	Day, Year)
		5	> Dane Da	wed The	Lui	20			261.				7/13	10	8
		VA	30. Name and address of person	who completed cause of	death (Ite	m 23a) (T	pe, Print)	Α.	0 0	1	~ n	. 1	7.	1	11/1/0. Do
			31. Date filed (Month, Day, Year)	cres DV	trar's Sign	ature	MNU	, W	D2	123	>0, 40	aul	Daw1	211	111/10120
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DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death **Physician** Rosa Maria Scott 2008 July 3:00an₩ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9125 Edgewood Drive Montgomery Gaithersburg If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)
Dec. 8,1917 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Days 1 □ M 2 🗓 F 90 213-56-7652 Dec. Peru Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a State 10h. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at MD Montgomery Gaithersburg Director 1XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9125 Edgewood Drive United States 20877 Funeral permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1XIYes 2□No 2 Specify: Peruvian Specify: White 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Enrique Chavanches Hermelinda Castro ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9125 Edgewood Drive Gaithersburg, MD 20877 Lorraine M.Scott (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July bate 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Alexandria, VA 2008 0 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licer 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovascular Accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami ertificate be executed burial-trar Due to (or as a consequence of): atten ing physician Physician/Medical the u: e as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) the 9 Unknown signed by the sign of the sign 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy The performed 1 ☐ Yes 2 ☐ No 1∐Yes 2√√No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 XNo Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) this r 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. Director: d in by the f 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide

Box 68760. Ö ۵, Division of Vital Records,

within 24 hours a

29a. Certifier

(Check only one)

Dr. Gary

31. Date filed (Month

29b. Signature applittle of certifier

₿.

Day,

Medical

State Registrar

DHMH 17 Rev 1/2001

nu

and manner stated.

gistrar's Signatur

30. Name and address/of person who completed cause of death (Item 23a) (Type, Print)

Wilkes M.D.

1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D552258

6095 Marshalee Drive Elkridge, MD 21075

29d. Date signed (Month, Day, Year)

July 4, 2008

	•	for State Registrar	State	of Mary	iana ,	Cei	ırtmer <i>tificat</i>	e of	leaith i Death	and IV	lental Hy	giene Reg. No	20	08	2362
Physicia /Medica		1. Decedent's Name (First, Middle, Shirley Sigal	Last)								2. Date of De July	ath 2, Day	200	)8 <sup>ear</sup>	3. Time of Death 7:40A.
Examine	_	4a. Facility Name (If not institution, Suburban Hospit	give street and nu	umber)				Town, or nesda	Location o	of Death				of Death ontgor	nery
Funeral Director		031-05-6027	6. Sex 1 ☐ M 2 🙀 F	7. Age (In	yrs. last 90	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Jan. 28	, 191	8	9. Birthpl Conne Conne	lace (State or Forei try) Cticut
with the Maryland a or 28a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgo	omery	100	* '	own or Lo		ng						10	0d. Inside City Limi 1 ∐ Yes 2 📉 N
with the	Director	10e. Street and Number 3330 North Leist	re World	l Blad			10f. Zip							Vhat Count	•
urs a	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	12. Was Dec Armed F 1 _ Yes If Yes, G Year or [	edent Ever orces? 2XINo ive oates:	in U.S.	1	Vas Dece fYes, spe ☐Yes	dent of H cify Cuba 2X No	Specify:		ecify Yes or No Rican, etc.)	)-	14. Raci Blac Specify	e - America k, White, e	an Indian, itc. ite
within 72 l liene. r than "nat	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (		$\dashv$	6a. Deced (Give life. L Jomem	kind of wo OO NOT u	al Occup irk done d se retired	ation during mos l)	t of worki	ng		ind of Bu	isiness/Ind	lustry
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, it is Medical once	To Be C	17. Father's Name (First, Middle, L Julius Alexander							18. Mothe Bessi		(First, Middle Lumen	, Maiden	Surnam	e)	
and 2 sho ealth and m 27 Is me her trauma	_15	19a. Informant's Name/Relationshi Charles Sigal - S	p (Type. Print) SON		6	643 J	ackso	n St	reet	Alba	al Route Numb	lifo	rnia	9470	06
Eages 1 tment of H tant: If iter jury or oth		20a. Method of Disposition  1	3 ☐ Removal from				moria	ol Ga	rdens	s 7/6	5/2008	Oln	ey,	Mary Mary	land
Physician /Medical Examiner  Permial-transit	edical Examiner	23a. Part 1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate eause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Card Due to  b. Due to	caused the each line.  Iiovas (or as a cor (or as a cor	cula nsequend	or Acceptable of the control of the	er the mod	le of dyir	g, such as	cardiac c	PAO BEI	rrest,		Mary	y1and2070 Approximate Interval Between Onset and Death
	Pnysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♠ No 9 □ Unknown		birth 2 🗍	Fetal de	ath 3 ⊑	Ectopic p Other (sp		у				23d. Dat Mo	e of delive	ry Day Year
uires that n signed build be deta	6	Part II. Other significant condition	es contributing to d	eath but not	t resultin	g in the ur	derlying c	ause giv	en in Part I.						e cause of death? ably 4  Unknow
: The law rec cate has bee page 2 shou	Completed										24a. Was auto perfo 1 ∐ Yes		ļ p	rior to con leath?	osy findings availab npletion of cause of 2  No
sician certifi irector	De C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	71	<u> </u>	(Oh hi		Oth	25:		(Check only o				
ending Phy eath. or: After this he funeral c	Certification: 10	27. Manner of Death  1  Natural 5 Pending 2  Accident investiga	28a. Date (Mor	Inpatient of Injury oth, Day, Yea	28	b. Time of Injury		8c. Injur Work	y at	1	me 5 ☐ Resí 28d. Describe				<i></i>
urs after daral Direct	Certific	3 Suicide 6 Could no determin	ed 28e. Place build	of Injury - ing, etc. (Si	pecify)					1	City or To	vn, State	)		Route Number,
he Hosp in 24 hol he Fune ipletely fi	edicai	29a. Certifier (Check only one)   ↑ Certifying  ↑ Medical E	Physician: To the xaminer: On the land man	e best of my pasis of examer nner stated.	/ knowled mination	dge, death and/or in	occurred restigation	at the tir i, in my o	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time,	date and	) and ma d place, a	anner as st and due to	tated. the cause(s)
V Lord Within	E	29b. Signature and title of certifier	1				290	D663	e number 804				_	2008	
		30. Name and address of person w Sujoy Tagor, M.I						Bet	hesda	ə, Ma	ryland	208	14		

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For State Registrar	State o	f Marylan		ertment of Stificate o		nd Men	tal Hygi	ene g. No. 20	08	236	529
	Physicia		Decedent's Name (First, Middle, Linda Sorbello	ast)						Date of Death		Year	3. Time of D	Death <b>A</b> M
	/Medic Examin		4a. Facility Name (If not institution, g  Casey House-Mon				•	, or Location of D		•	4c. County		У	
	Funeral Director		,	Sex 1 M 2 A F	7. Age (In yrs. 4		If Under 1 Year Months Day		Min. 8. D	Date of Birth Month, Day 1g • 30	Year) 1963	9. Birthp Cour New	olace (State or ork York	Foreign
A CONTRACTOR OF THE PROPERTY O	a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgome	ery		y, Town or Lo						1	0d. Inside City 1 □ Yes 2	
odt divis	3a or 28a	Funeral Director	10e. Street and Number 18219 #4 Swiss Co	<del>-</del>	1		10f. Zip Code	∍ 874			g. Citizen of V U <b>nited</b>		-	
UUSO	", or items ?	by Funer	11, Marital Status  1   Never Married 2   Married  3   Widowed 4   Divorced	12. Was Dec Armed Fo 1 ∐Yes If Yes, Gi Year or D	2X No ve		Vas Decedent of Yes, specify Co	of Hispanic Origin uban, Mexican, F lo Specify:	n? (Specify Puerto Ricar	Yes or No- n, etc.)		k, White,	ean Indian, etc. hite	
12.13-U	within 72 non	Completed	15. Decedent's (Specify only highest g	Education rade completed) College ('	1-4or 5+)	(Give life. I	dent's Usual Occ kind of work dor DO NOT use reti ter Eng	ne during most o ired)	of working		6b. Kind of Bu			
ario (log)	ental Hygie ked other t c event, th	To Be Co	17. Father's Name (First, Middle, Last Francis G. Sorbe	st)		Сопра	cer mig	18. Mother's			aiden Surnam			
Mary	afth and M 27 is mar	F	19a. Informant's Name/Relationship Francis G. Sorbe	(Type. Print) 11o (Fat	her)	19b. Mailir 3 Pa	ng Address (Stre	et and Number 1e, Newl	or Rural Ro. burgh,	ute Number, New	City or Town, York 12	State, Zip 2550	Code)	
Dalilliore,	perfilt. Tages I and 2 should be med within 72 hours after beath with the waryand Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "natical Eventries must be notified at once.		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spec	cify)	State	Metrop Cremat	. Name and Ad	dress of Facility		·   revol F	uneral	lria, Home	Virgi	
	hysícian		23a. Part I/ Enter the disease or co shock, or hear failure. List onl	y one cause on e	caused the deatleach line.	n. Do not ent	er the mode of o		ardiac or res			irg,	MD 2083 Approximate Interval Betw Onset and De	veen
E	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	disease or condition resulting in death)  Sequentially list conditions, farry, and good conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	(or as a consequence of as a consequence of as a consequence of as a consequence of a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a consequenc	uence of):								
D. DOX O	y the attending	ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩ No 9 □ Unknown	1 Live	itcome of pregna birth 2□Feta gnant at time of c nown	I death 3	Ectopic pregna Other (specify					te of deliv		ear
Co, T	n signed by	d by Phy	Part II. Other significant conditions	contributing to d	leath but not res	ulting in the u	nderlying cause	given in Part I.					he cause of de	
al necords,	icate has been	Completed									ned?	Were auto prior to co death? 1 □Yes	opsy findings a empletion of ca	vailable use of
VISION OF VIL	ath.  r: After this certil e funeral directo	ation: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  27. Manner of Death  1 ☒ Natural 5 ☐ Pending investigati	28a. Date (Mor	Inpatient 2  of Injury oth, Day, Year)	ER/Outpatier 28b. Time o Injury	28c. Ir	Othor:	sing Home		e) nce 6区Oth w injury occurr		<sub>fy)</sub> Hosp	pice
	rs after dea al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e. Place build	e of Injury - At ho ling, etc. <i>(Specit</i>	ome, farm, str	eet, factory, offic	ce		Location (Str City or Town		er or Run	al Route Numb	er,
the Hoeni	the Funer	edical	(Check only one) Medical Ex	Physician: To the aminer: On the land mar			vestigation, in m	ny opinion, death		it the time, da	ate and place,	and due t	o the cause(s)	
Ę	30	M	29b. Signature and title of certifier	Wr	o la	2 ~	_ I	ense number 064615			July 5	, 200	08	
Par.			30. Name and address of person wh Genevieve Wroble 31. Date filed (Month Pey, Year)		se of death (lten			ive,Suit	e 100	, Rock	ville,	MD 2	20850	
	Sta Registr		51. Date filed (MONITURY, 1947) 7	2008 32.	aylarai s Siylla	J. A	parti							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 08 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 子: CO AM aroline Janes C 7 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗹 F 218-80-8092 Director 91 April 6, 1917 West Virginia Usual Residence of Decedent 10c. City, Town or Location a or 28a-f show be notified at 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2505 Sheraton Street 20906 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a any injury or other traumatic event, the Medical Examinar once. ral", or items 23a Examiner must b USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ MNo Specify. Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Martin Janes Ruby Meredith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Howard Sipes/Son 2505 Sheraton Street, Wheaton, MD 20902 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State July 10 2008 MD Veteran's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service License 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** suppration /Medical Due to or as a consequence of): Examiner reumania Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed for use as the burial-transi engestin Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ned by the a' P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by been signe should be ( 3 ☐ Probably 4 ☑ Unknown 1 🗌 Yes 2 □ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No ate has page 2 s 2 No certificate 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ funeral 27. Manner of Death 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

State

completely i

31. Date filed (Month, Day, Year)

Smitha Bhikkaji, MD

29b. Signature and title of certifier

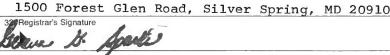
29a, Certifier

(Check only one)

Medical

JUL 0 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Registrar

tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D0064100

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 23631 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Singer Mollie Η. 12:30 A M 2008 July 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring
If Under 1 Year If Under 24 Hrs. Montgomery Holy Cross Hospital 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1 □ M 2 🔀 F 88 059-14-0184 Director June 3, Hungary 1920 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 10a, State show if than "natural", or items 23a or 28a-f show the Weddal Even in it has notified at 1 □Yes 2 NNo Director Silver Spring MD Montgomery 10f. Zip Code 10e Street and Number 10a, Citizen of What Country? U.S.A. 20901 10911 Hannes Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0wn Home Homemaker permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname)
Rose Siegelman 17. Father's Name (First, Middle, Last) Be Handin Zoltan 19a. Informant's Name/Relationship (Type. Print)
Michael Singer / son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2621 Bradshaw Terrace, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lebanon Cemetery | July 8,200\$ Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Fune I Se 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Respiratory Failure **Physician** /Medical Due to (or as a consequence of): Examiner Severe Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off executed and Due to (or as a consequence of): attending physician for use as the buria Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physiciar completely filled in by the funeral director, page 2 should be detached for use as the hurris Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 T Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2∭XNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) July 6, 2008 D63579 10 30. Name and address presson who completed cause of death (tem 23a) (Type, Print) Glen Rd., Silver Spring, MD 20901 Maria J. ayaq 31. Date filed (Month, Day, Registrar's Signature State 08 2008 JUL Registrar

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Registrar

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Year)

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31. Date filed (Month, Day,

32. Registrar's Signature

# Baltimore, Maryland 21215-0036

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Vital Records, P.O. Box 68760,	
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Division	

			Please	e Type or Prin					-		ible.		
	-	For State Registrar		State of Ma	arylan		partment of H <i>ertificate of I</i>				200	000	( ) )
		Registrar  1. Decedent's Name	(First, Middle, I	as <i>t</i> )			Crimoato or i	Journ	2. Date of Dea		108	3. Time of	535 Death
Physicia		Judy Mar	rie Sha	nk					June 2	9 200	Year 8	6:00	PM M
/Medic	. 90	4a. Facility Name (If I	not institution, g	ive street and number)			4b. City, Town, or	Location of Death			ty of Death		
	*			tal Center	- ()	la a t la latte de	Westmins	ter If Under 24 Hrs.	8. Date of Birth	Carr		lana (Cinta a	u Come town
Funeral Director		5. Social Security Nu		1 DM 277 E	e ( <i>In yr</i> s. 1 68	ast birthda Yrs	Months Days	Hours Min.	(Month, Day	, Year)	Coun	lace (State of try) sylvan	
je retrota na stanik S		161-32-27 Usual Residence of D							4/1//1	.940			
iryland ihow	_	10a. State	10b. County			, Town or					1	0d. Inside Cit 1 ☐ Yes	
with the Marylan a or 28a-f show be notified at	Director	MD	Carrol.	<u> </u>	,	Sykes	ville			l 0g. Citizen of	Mhat Cour		22.140
with t	ă	10e. Street and Num					10f. Zip Code 21784			Inited			4
death w	Funeral	7010 Can	rmae ka	12. Was Decedent	Ever in U.	S. 1	3. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp			ace - Americ	an Indian,	
ours after de ral", or item Examiner r		1 Never Marrie		Armed Forces? 1 ☐ Yes 2 ☐ ☐ Yes, Give	No		1 ☐ Yes 2☐ No	Hican, etc.)	Spec	ack, White,	ite		
"natural",	d by	3 ☐ Widowed 4		Year or Dates:		10- D-		Specify:		essiene.			
n 72 hc	lete	(Specif		grade completed)		(G. life	cedent's Usual Occup ive kind of work done o e. DO NOT use retired	during most of work d)	ding	16b. Kind of I	ousiness/inc	uustry	
d withing jiene.	Completed	Elementary/Secon	idary (0-12)	College (1-4or 5	)+)	Ar	tist			Self E	mploy	ed	
be filed within 72 hours after death with the Maryland tall Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be	17. Father's Name (F						18. Mother's Nam		Maiden Surna	ime)		
ould b Ment arkec	卢	Edward I				1		Ethel Al					
d 2 sh th and 7 Is m traum		19a. Informant's Nar					ailing Address <i>(Street</i> ) Carmae Ro					(Code)	
1 and Healt Jem 2		Jay Shanl	osition		20b. P		sposition (Name of crematory or other place		Date TIL	20c. Location		own, State	
Pages ent of nt: If is		1 ☐ Burial 2x ☐ 4 ☐ Donation	Cremation 3	☐Removal from State cify)	- 1		Carroll Cre	F	008	Winfie	ıld. M	D	
permit. Pages 1 and 2 should be filed within 72 P Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "nat any injury or other traumatic event, the Medica once.	1	21. Signature of Fur			1 50	qui (	22 Name and Addre	ss of Facility					Δ
8 3 1 2 5		Todal	H.,	blen		- 3	Burrier-Ou 1212 W. Ol	d Libert	y Rd. Wi	nfield	, MD		
		snock, or near	t failure. List of	omplications that caused ly one cause on each li	ne.			337	or respiratory ar	rest,		Approximate interval Bet Onset and I	ween
Physician /Medical		Immediate Cause (F disease or condition resulting in death)	Final		06		) ROSE	0513				5 D	Mys.
Examiner			1	Due to (or as	a consequ	uence of):	SING U	IRINA	24 C4	STIT	15-		
	Jer	Sequentially fist confif any, leading to imrecause. Enter Under	mediate	Due to (or as			21/100 0	1-1	1				
e executed ian and urial-transit	Examiner	Cause (Disease or in that initiated events resulting in death) La	njury	с									
	Ξ1	resulting in death) La	aoi	Due to (or as	a conseq	uence of):							
The law requires that the death certificate be ate has been signed by the attending physicis bage 2 should be detached for use as the bur	Physician/Medica			d									
leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome			0			23d. E	Date of deliv	ery	
death	sicla	in the past 12 r 1 ☐ Yes 2 ☐	months?	1□Live birth 4□Pregnant a 9□Unknown			3 □Ectopic pregnancy 5 □ Other (specify) _	у		1	Month	Day \	Year
at the de d by the etached	Phys	9 Unknown				ulainen in ale	- undaduina agua a siu	rem in Dort I	220 Did to	obacco use co	entribute to 1	he cause of o	heath?
ires that signed by	þ	Part II. Other significant	1) L ( N	s contributing to death b		ulling in th	DIAR	TES	23e. Did to				Unknown
w requires been signe should be	etec	000	ONA	24 00	TCI	24	DICLA	-6-	24a. Was	an 24k		opsy findings	available
siclan: The law certificate has b irector, page 2 s	Completed	COR	COVA	1712	-( )		0138113		autop perfo	rmed2	prior to co death? 1 ☐ Yes	mpletion of c 2 □ No	ause of
	Be Co	25. Was case referre	red to medical	(3				26. Place of Dea		ne)	1 1 162	2 140	
Physicl this ce al direc	To B	examiner? 1 ☐ Yes 2☐1	No	Hospital: 1 Inpatio	ent 2	ER/Outpa	tient 3 DOA Oth	er: 4 ☐ Nursing H	ome 5 ☐ Resid	lence 6 🗆 C	ther (Speci	fy)	
ing Pl	on:	27. Manner of Death	5 Pending	28a. Date of Inju (Month, Da	ıry y Year)	28b. Tim Inju	ry Wor		28d. Describe h	ow injury occ	urred		
ttend death.	icati	2 ☐ Accident 3 ☐ Suicide	investigat 6 ☐ Could no	be 28e Place of ini	urv - At ho	ome. farm.	M 1 □	Yes 2 □ No	28f. Location (S	Street and Nur	mber or Rur	al Route Num	nber.
after after I Direct	Certification:	4 ☐ Homicide	determin	building, e	c. (Specif	y)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tou	vn, State)			·
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Salc	29a. Certifier (Check only	Certifying	Physician: To the best caminer: On the basis of	of my kno	wiedge, d	eath occurred at the ti	me, date and place	, and due to the	cause(s) and	manner as	stated.	(9
ro the Hovithin 24	Medical	one)		and manner st		tilon and/o							"
With COU	2	29b. Signature and	title of certifier	nan	2		29c. Licens		1	29d. Date sign	ned (Month,		
MIL		20 No.		on completed assess of	loath /lt	0 220\ /T	no Print\	111000	M ( )	1.17	11	- 0	
6		Name and addre	TPE	no completed cause of c	eath (iten	22U	WAST	111000	N 47.17	·WE	300	21115	)
Sta	te	31. Date filed (Monta		32. Registi							<u> </u>		
Registr	ar		JUL 0	8 2008	eur	K	South						

1 - For State Registrar

	Physici /Medic		Decedent's Name (First, Middle, Late LINDA LEE STON)						2.	MULY	8, <sup>Da</sup> 200	)8 Year	3. Time of Death 1138 M
	Examir	_	4a. Facility Name (If not institution, giv GOLDEN LIVING CE		er)		4b. City, Tow	HAGE	RSTOWN		4c. Cour		HINGTON
新	Funeral Director		5. Social Security Number 6. S 220–38–5194 1  Usual Residence of Decedent	ex	Age (In yrs. las	st birthday) Yrs.	If Under 1 Your Months Da	ear If Und		Date of Birth (Month, Day Y 27,	1943	9. Birthp Coun MAI	lace (State or Foreign stry) RYLAND
	e Maryland a-f show tified at	ctor	10a. State 10b. County MARYLAND WASHI	NGTON	10c. City,	Town or Lo		[AGERS]	COWN				0d. Inside City Limits 1 XYes 2 No
	with the	I Director	10e. Street and Number 750 DUAL HIGHWAY				10f. Zip Co	1e 2174(	)		10g. Citizen o	of What Cour	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show may Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Tovorced	12. Was Deceded Armed Force 1 Test 2 If Yes, Give Year or Date	es? <b>X</b> No		Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2ሺ No Specify:						
2-00	72 hou 'natura dical E	eted	15. Decedent's E	ducation ade completed)		16a. Dece	dent's Usual O kind of work d DO NOT use re	ccupation one during m	ost of working	I	16b. Kind of	Business/Inc	
2121	l within giene. r than '	Completed by	Elementary/Secondary (0-12) 12	College (1-4	or 5+)	IITO. I	CLE					BANK	ING
Maryland 21215-0036	uld be filec Mental Hyg irked other itic event,	To Be C	17. Father's Name ( <i>First, Middle, Last</i> CHARLES HALBERT						ther's Name <i>(F</i>			ame)	
	and 2 sho ealth and I m 27 Is ma her trauma		19a. Informant's Name/Relationship ( VICTORIA GUDEMAN			31 N	. MAIN	STREE	nber or Rural F	YSVILI	LE, MAI	RYLAND	21756
Baltimore,	. Pages 1 tment of H tant: If Iter fury or otl		20a. Method of Disposition  1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	'y)	cei	HAVE	nsition (Name of matory or other N MEM.	PARK	7/11/2	800		BURNIE	, MARYLAND
Ba	permit Depar Impor any In		21. Signature of run:  23a. Part 1. Enter the disease, or conshock, or near failure. List only	Dications that car	used the death.	76	06 Old	Nation	nal Pik	e, Boo	onsboro	eral H o, Mar	ome, P.A. yland 217 Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or	Cordiv r as a conseque	hulm	ionary	an	est	<i>L</i>			Onset and Death
	Examiner	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or	r as a conseque	ence of):	grean of si	dial	marci	um			ems_
,092	te be execut ysician and te burial-tran	ical Examiner	that initiated events resulting in death) Last	Due to (or	r as a conseque r as a conseque r as a conseque Affur r as a conseque	ence of:	se m	llifa	us			1	years
.O. Box 68760,	he death certificate be executed the attending physician and shed for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Fetal on the at time of dea	death 3	⊒Ectopic pregr ∃ Other <i>(speci</i> i					Date of deliv Month	ery Day Year
<u>α</u>	w requires that the c been signed by the should be detached	<b>₽</b>	Part II. Other significant conditions	contributing to dea	th but not result	ting in the u	nderlying caus	e given in Pa	rt I.	23e. Did to			he cause of death?
Il Records,	. The law requires that the cate has been signed by the page 2 should be detache	Completed		typenter	nsim	llate	m'			24a. Was autor perfo 1∐ Yes		prior to co death?	opsy findings available impletion of cause of
Vital	rsiclan s certific lirector,	Be	25. Was case referred to medical examiner?	Hospital: 1 🗆 Ini	patient 2 □ E	R/Outpatie	nt 3□ DOA		ace of Death (6			Other (Speci	fv)
n or	Ing Phy After this uneral o	on: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of (Month		28b. Time o		Injury at Work?	28		how injury occ		
Division or	or Attendate after death Director:	Certification:	2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place o	of injury - At hon g, etc. <i>(Specify)</i>			1 ☐ Yes 2		f. Location (S City or Tou		ımber or Rur	al Route Number,
	Hospita 4 hours Funeral ely fillec	Medical Co	29a. Certifier 1. Certifying P (Check only one) 2  Medical Exa	hysician: To the bas miner: On the bas and manne	sis of examinati	rledge, deal on and/or in	th occurred at to	he time, date my opinion,	and place, an death occurred	d due to the I at the time,	cause(s) and date and pla	manner as s ce, and due	stated. to the cause(s)
)	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	1			29c. Li	cense numb 4499	•		July	0	2000.
7	14-8		30. Name and address of person who	K MD	20	3//	Brint) pp	ms k	ed B	ionsb	no	Mø.	21713.
	St	ate	31. Date filed (Month, Day, Year)	2008 32. Re	ortrar's Signati	lre M	Smalle	7					

Division or Vital Records, P.O. Box 68760, or Attending

24 hours after death e Funeral Director: filled in by

3H-5 State

the within To the

Habib Chotani

MD

29c. License number

1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

D58853

July 8,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

251 E. Antietam Street Hagerstown, Maryland

31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 09 2008

Medical

29a. Certifier

29b. Signature and title of certifier

State of Maryland / Department of Health and Mental Hygiene 008 23636 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2008 JULY 12, Physician 2045 Thomas Edward Schroyer /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CUMBERLAND ALLEGANY WMHS-Memorial Campus If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F May 31, 1940 Maryland 212-38-5511 Director 68 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show Examiner must be notified at 1 Yes 2 No Director Grantsville Garrett MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 0 USA or Items 23a 21536 2903 Chestnut Ridge Rd. Funeral death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or Item any Injury or other traumath. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Construction Company 12 Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Stark ည Orval Schroyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2903 Chestnut Ridge Rd., Grantsville, MD Patricia A. Schroyer/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Grantsville Cemetery July 15, 2008 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funerat Service License Q-other P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Left Middle Cerebral Artery Stroke disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any leading to immedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the huria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>გ</u> 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2 No 1∐ Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA 1 🗹 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 2 Accident death within 24 hours after death To the Funeral Director: 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

D0065702

Cumberland, MD. 21502

JULY

2008

MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9,00

2008

Seton Drive

32. Registrar's Signature

08-05384 Michael Shawn Simons

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 23637

		1- For State Certificate of Death	7	Reg	. No.	
Physicia	n/	Decedent's Name (First, Middle,Last)		2. Date of Death	Day Year	3. Time of Death
ledical Examin		HICHACI BIRWII BIRGIIS		July 13, 200	)8	2023 hrs
	b.	4a. Facility Name (if not institution, give street and number)  Garrett County Memorial Hospital  Oakla	own, or Location of De	eath	4c. County of Death Garrett	1
Formani			r 1 Year If Under 24	Hrs 8 Date of Birth	(MM/DD/YYYY) 9. Bir	thplace (State or
Funeral Director		Months		Min.	Foreig	
	-	235-25-4879   1X M 2 F   30 Yrs.   Usual Residence of Decedent		March	12 1978	MD MD
any	ŀ	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
<u>*</u>		WV Mineral Elk Garden				1 X Yes 2 No
Aaryland 28a-f show 1 at once	왕	10e. Street and Number 10f. Zip	Code	100	. Citizen of What Cou	ntry?
he M	Director	P.O. Box 66	17	1	United St	ates
death with the Maryland or items 23a or 28a-f sho must be notified at once	L	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Deceder	nt of Hispanic Origin?		14. Race - Amer	ican Indian, Black,
death r iten	Fune	1 X Never Married 2 Married Armed Forces? If Yes, specify 1 Yes 2X No	y Cuban, Mexican, Pue	erto Rican, etc.)	White, etc.	
after o	P.		X No specify:		Specify: Wh	ite
natur Xami		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual ( during most of world	Occupation (Give kind king life. DO NOT use		16b. Kind of Business/	Industry
36 hin 72 l e. than "1	Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)		,		
5-0036 iled within 72 Hygiene. I other than '	E .	12 Laborer 17. Father's Name (First, Middle, Last)	19 Mothor's No	ame (First, Middle, Ma	Coal	
15-	Be C	Denver Simons	Patri		olvard	
2121 ould be fi   Mental     marked   ic event,					er, City or Town, State	e, Zip Code)
MD 21215-0036 12 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 12 is marked other than "natural", or items 23a or 28a-f shounatic event, the Medical Examiner must be notified at once		Patricia Simons, Mother P.O. Box	66, Elk Ga	arden, WV	26717	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	=	20a. Method of Disposition  20b. Place of Disposition (Nam  1 X Rudial 2 Commetting 3 Page val from State crematory or other place)		Date	20c. Location - City or	Town, State
Baltimore, Normit Pages I and Department of Healt Important: If item Imjury or other transity or other transity or other transity or other transity.		TX - 11 1 C		07/17/2008	Elk Gard	en. WV
Baltir permit. I Departm Importa injury or					Home, P.A	
E P P E		Katherene Nueiter 710 C	hurch St.,	Kitzmille	er, MD 215.	38
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each me.	of dying, such as cardia	ac or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
'Medical xaminer		Immediate Cause (Final disease a. Multiple Injuries	10			Death
A.G.IIIII.O.		or condition resulting in death)  Due to (or as a consequence of):		-		
	- l	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	틝	Couse. Enter Underlying Couse (Disease or injury that initiated				
ed nsit	Examiner	events resulting in death) Last Due to (or as a consequence of):				
760, Trate be executed physician and the burial - transit		UNPENDED AMENDED				
30, te be or sysicize buria	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	\
68760, certificate be nding physici se as the buri		23h Was decedent pregnant in the	3 Ectopic pre	egnancy		Day Year
Box 687 ne death certific the attending	Si	1 Yes 2 No 9 Unknown Q Unknown	cify)	Eq.	İ	
B. Be de he de he de fahed fa	Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I	23e Did toh	pacco use contribute to	the cause of death?
ires that the signed by a detached	ē		cause given in raici.			bably 4 Unknown
dS, equire	ompleted			   24a. Was a	n   24b. Were a	utopsy findings available
cords law requi	힐			autops		completion of cause of
tal Rectian: The	Ö			1 <b>✓</b> Yes 2	No 1 ✓ Y	es 2 No
of Vital Records, ng Physician: The law require the this certificate has been simeral director, page 2 should be	Be	examiner? Hospital:	26.Place of Death (Ch		Residence 6 Other	
n of V ding Phys After thi funeral di	£	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 2	28c. Injury at Work?		ow injury occurred	
ion C tending eath. tor: Af	<u>[</u> ]	1 Natural 5 Pending Jul 13, 2008 1900 hrs	1 Yes 2 V No	Driver auto c	ollision	
Division rate of a strength of a strength.	ertification	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory	, office building, etc.	28f. Location (St	reet and Number or R	ural Route Number, City
Division spital or A spital or A spital or A spital Direction of the filled in I	e i	Suicide 6 Could not be determined (Specify) Local Street		or Town, St. Route 50, 1 mi	<sup>ate)</sup> le west of Route 42	, Mt. Storm, WV
Hosp 24 hou Fune stely fi	a	29a. Certifier Check only Check only Check only Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the	time, date and place,	and due to the cause	(s) and manner as sta	ted.
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.		red at the time, date a		
	Ž	29b. Signature and title of certifier	c. License number		29d. Date signed (M	onth, Day, Year)
		John Brasself, MD	O.C.M.E.		July 14, 2008	
	3	30. Name and address of person who completed cause of death (Item 23a)	reet, Baltimore, N	MD 21201		
				VID 2 1201		
St: Regist	ate rar	In III → ► 2000 18%				
DHMH 17 Rev 1/20	001	OCME ORIGINAL				

			State of Maryla  1 - State Registrar  Amend Items 25,27,28a-	nd/Depa E <b>per</b> n	artment of Ho	ealth and M <b>/21//08dh</b>	lental Hygid b	ene 2008	23638
h	Dhysisi		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia Medic/		J. C. THOMAS				06	22 2008	10:24P M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County of Death	
			Randolph Nursing & Rehabilitat  5. Social Security Number 6. Sex 7. Age (In year	ion :. last birthday)	Wheator If Under 1 Year	n If Under 24 Hrs.	8. Date of Birth	Montgomer	y nplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs 250–30–4380 82	Yrs.	Months Days	Hours Min.	(Month, Day, 1 11/29/1	Year) Cou	h Carolina
	- 100		Usual Residence of Decedent				11/2//1	723 15000	
	ırylan show	_	10a. State 10b. County 10c. C	ity, Town or Lo	cation				10d. Inside City Limits 1 Yes 2 □ No
	ne Ma 8a-f s atifie	Director		lver Sp					
	with th		10e. Street and Number		10f. Zip Code 20904		109	g. Citizen of What Cor USA	untry?
	eath v	eral	12905 Chathlake Lane 11. Marital Status 12. Was Decedent Ever in	J.S. 13.1			ecify Yes or No-	14. Race - Amer	ican Indian,
_	be filed within 72 hours after death with the Maryland tral Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☒ Yes 2 ☐ No		Was Decedent of His If Yes, specify Cubar		Rican, etc.)	Black, White	
2-0036	ours a ral", o Exan	by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates: WW-]	I	1⊡Yes 2∭XNo	Specify:		Specify: B1	ack
2	72 hg 'natu dical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa kind of work done di DO NOT use retired)	ation Juring most of work	ting 1	6b. Kind of Business/I	ndustry
7	within	E D	Elementary/Secondary (0-12) College (1-4or 5+)			,	į	Self Empl	ovad
N D	filed within 72 h 1 Hyglene. other than "natuent, the Medica		17. Father's Name (First, Middle, Last)	Masc	nary	18. Mother's Name	e (First, Middle, Ma		Oyeu
and	lould be Mental narked o	To Be	Julius Waliey			Earli	ne Thoma	S	
ary	2 should and Men is marke aumatic	<b>F</b>	19a. Informant's Name/Relationship (Type. Print)					City or Town, State, Z	
, Ra	s 1 and 2 sh f Health and item 27 is n other traun		Mark Avery Thomas - son	1			Silver Sp	ring MD 20	904
Baltimore,	00		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State	Place of Dispo cemetery, crer	sition (Name of matory or other place	9)	1	0c. Location - City or	
Ě	. Pages tment of I tant: If ite		4 □ Donation 5 □ Other (Specify)	1	ion Cemet			linton, Ma	-
Za Za	permit. Pag Department Important: I any injury o	j	21. Signature of Funeral Service Licensee	111 //				Funeral Ho	
	ED = e O		J.P. MArshall  23a. Parti. Enter the disease, or combications that caused the deshock, or heart failure. List only be cause on each line.	th Do not ent	er the mode of dvino	ST. N.W.	or respiratory arres	ston, D.C.	
	Division	N A	shock, or heart failure. List only one cause on each line.		O c	- / 1 / 1 / 1	or respiratory arres	5.,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  Due to (or as a conse	quence of):	PNE	EUMON	114		DHYS
	Examiner			·			11		
٩,	D #	ner	Sequentially list conditions, if any, leading to infine dist. Cause. Enter Underlying Cause (Disease or injury	querine off:		0.	N APPROVED BY ME	DICAL EXAMINER	
	acute and trans	Examiner	that initiated events c.			150	N APPROVED BY ME	Dio -	
Ď,	icate be executed physician and s the burial-transit	E E	Due to (or as a conse	quence or):		CERTIFICATION	, -		
28/60	the death certificate be executed y the attending physician and iched for use as the burial-transit	dical	d						
POX	leath certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome pf preg		-			23d. Date of deli	very
	death e atte d for	icia	in the past 12 months?  1☐ Ves 2☐ No.		Ectopic pregnancy Other (specify)			Month	Day Year
j.	t the by the tache	hys	9 ☐ Unknown 9 ☐ Unknown						
Ś.	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not re		_			acco use contribute to	
Records,	een s	Completed by	WIP FRACTURE, HYPERTEN			. ,		1	
ec C	e 2 sh	nple	DIABETES, CORONARY ART	CRY I	USEASE,	PUZMONAI		24b. Were au	topsy findings available completion of cause of
	sician: The law certificate has E lirector, page 2 s		EMBOLISM, CHRONIC OBSTRUCT	IVE LU	NU DISC			☑No 1 □ Yes	2 □ No
VII	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?  1 ★ Yes 2 ★ Hospital: 1 □ Inpatient 2	TER/Outpotion	othe		th (Check only one	nce 6 ∐Other (Spec	-7.)
Ö	y Phy er this eral di	: To	**	28b. Time of	f 28c. Injury	at	ome 5 ☐ Hesider 28d. Describe hov		ory)
0	Attending r death. ector: After by the fune	atior	27. Manner of Death  1	Unknow	a Work n 1□Y	res 2 <b>X</b> No	Subject	fell	
DIVISION OF	al or Attendii safter death. Il Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State) <b>12905</b> C	ıral Route Number,
5	ital or rs afte ral Di	Cer	Home				Lane, Sir	ver spring	, MD
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Physician: To the best of my king (Check only onle) 2 Medical Examiner: On the basis of examination and manner stated.						
	o the ithin 2 o the omple	Med	one) and manner stated.  29b. Signature and title of certifier		29c. License	number	29	d. Date signed (Monti	h, Day, Year)
1	⊢≯⊢ŏ		> Imenorally Acu	m, si	000	57636		6-25-	2008.
7			30. Name and address of person who completed cause of death (lite	em 23a) (Type,	Print) Anura	dha Arun			
			10301 CIEURGIA AVE, STE	209,	SILVER			D 2090	2
	Sta		31. Date filed (Month, Day, Year)  22. Registrar's Sig	nature	as b				
	Registr	ar	HIN 3 0 2008	0000	St I				

08-05093 Scott Tran Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 23639

		For State	Certif	icate of i	Death		, ,	Reg. I	No.	00 2000	
Physician/ Jedical Examine	1.	Decedent's Name (First, Middle,Last)	RAN					Date of Death Month Da July 2, 2008		3. Time of Death 2142 hrs	
	48	a. Facility Name (if not institution, give street and n Holy Cross Hospital	iumber)	4t	Silver Spr	or Location of ing		de.	4c. County of Dea Montgomery		
Funeral Director		Social Security Number 218-63-1217 6. Sex 1 M 2 F	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Y Months D	ear If Under ays Hours	Min.	April 2	MM/DD/YYYY) 9. B Fore 3,2002	irthplace (State or eign country) MD	
Aaryland 13a-f show any Latonce. ector	10	sual Residence of Decedent  Da. State 10b. County  MD Montgomery		wn or Locatio	urg			100	Citizen of What Co	10d. Inside City Limits 1 Yes 2 X No	
the Maryland a or 28a-f sh biffied at once		De. Street and Number 8840 Cross Country Pla	ce		10f. Zip Code	20879			nited Sta	ites	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If liem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	3		ear	If Ye	es, specify Cut $_{ m Yes}$ 2 $\overline{ m X}$	No specify: pation (Give k	Puerto Ri	rk done 16	14. Race - Ame White, etc. Specify: A:	sian	
5-0036 cel within 72 hour lygiene. to ther than "natt the Medical Exa	hiere	Elementary/Secondary (0-12) College	(1-4 or 5+)	Studer	_	life. DO NOT t	use retired	]	Elementar School	У	
215-0036 be filed within 7 mtal Hygiene. rked other than ent, the Medica		7. Father's Name (First, Middle, Last) Si Dinh Tran				Camy	-Thi	First, Middle, Mai Nguyen			
MD 212 d 2 should but and Mental m 27 is marl anmatic eve	2 1	9a. Informant's Name/Relationship (Type, Print) Si Dinh Tran (Father)						ce Gaitl		MD 20879	
Baltimore, Moemit. Pages I and Department of Health Important: If item injury or other trau		0a. Method of Disposition  1 X Burial 2 Cremation 3 Removal  4 Donation 5 Other Specify:	from State cre	nce of Disposi matory or oth of He	er place) eaven (	Cem.	July 200	7 7,		or Town, State	
Balti permit. Departs Import	V.	1. Signature of Funeral Service Licensee		10	East	Deer Pa	ark I	or. gait		, MD 20877	
Physician 'Medical ∡aminer	1	3a. Part I. Enter the disease, or complications that failure. List only one cause on each line.  mmediate Cause (Final disease or condition resulting in death)  Due to (or as			e mode of dy	ng, such as ca	ardiac or i	respiratory arrest	, shock, or heart	Approximate Interval Between Onset and Death	
ed Insit Evaminer	Examiner										
760, frate be executed physician and the burial - transit	UNPENDED AMENDED										
ox 68 ath certif attending or use as	cian/	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)  23d. Date of delivery Month Day Year									
ords, P.O. Be w requires that the de as been signed by the should be detached for the property of the property	a	Part II. Other significant conditions contributing	g to death but not res	ulting in the u	ınderlying cau	se given in Pa	art I.		2 No 3 F	e to the cause of death?  Probably 4  Unknown  e autopsy findings available	
of Vital Records, ng Physician: The law require Nfer this certificate has been si nneral director, page 2 should t	Completed				26.5	lace of Death	(Chock o	autopsy perform 1 Yes 2	prior death	to completion of cause of	
Vital hysician: this certi	lo Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	Inpatient 2 🗸 E		3 DOA	Other <sub>4</sub>	Nursing	Home 5 R		ther:	
Division of Vital Pipilal or Attending Physician: ours after death.  The Director: After this certification by the funeral director.		1 Natural 5 Pending FOU	onth, Day,Year)	28b. Time of <b>i</b> FOUND: 2035 hrs	' ' I ,	Injury at Work Yes 2	No	Subject drfov	ow injury occurred vned in swimm		
Division the Hospital or Attendifin 24 hours after death. the Funeral Director: /	┋	3 Suicide 6 Could not be 28e. P	lace of Injury - At hor ify) Swimming F		et, factory, off	ice building, e		or Town Sta	ate)	r Rural Route Number, City , Silver Spring, MD	
0 E F	ल 1	29a. Certifier 1 Certifying Physician: To the (Check only one) 2 Medical Examiner: On the base	sis of examination and	e, death occui d/or investiga	rred at the tim tion, in my op	e, date and pl inion, death o	lace, and courred at	due to the cause the time, date a	(s) and manner as nd place, and due t	stated. to the cause(s)	
	¥ -	29b. Signature and title of certifier	er stated.		- 1	.C.M.E.	OCM	E	29d. Date signed July 4, 2008	(Month, Day,Year)	
2	3	3. Name and address of person who completed Theodore M. King, Jr., MD. Assi	al se of deth (Item : stant Medical E:		111 Penr	Street Ba	altimore	, MD 21201			
Stat	te		Roistrar's Signatur		ask i						

			For State	State o	of Maryland	d / Depa	artment of F	lealth	and M	lental Hyg	iene 2 (	008	23640
- 4			Registrar  1. Decedent's Name (First, Middle				timodito or			2. Date of Deat	eg. 110,		3. Time of Death
	Physicia	an	,		mii v vu	PON				Month JULY	Day	Year 2008	9:30 A M
	/Medic		ROOSEVI  4a. Facility Name (If not institution.		THAXT	LON	4b. City, Town, o	r Locatio	n of Death	JULI		ty of Death	
ļ.,	Examin	er	,		77				RLBOR	0		•	EORGES
	Funcional	2000年	13524 NEW ACAI 5. Social Security Number	OIA LA. 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Und	er 24 Hrs.	8. Date of Birth		9. Birth	place (State or Foreign
	Funeral Director		032-12-2828	1 <b>X</b> M 2 □ F	80	Yrs.	Months Days	Hours	Min.	JAN 18,			RGINIA
Ġ.,	Charles and		Usual Residence of Decedent							02111 103	1,20		
	show ad at		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
:	Mar Fied	호	MD. PRINCE	E GEORGES			UPPER MA	ARLBO	ORO				1 XYes 2 □ No
:	r 28g	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen o	f What Cou	ntry?
	n wit		13524 NEW A	ACADTA LA				20774	4		U	.S.A.	
	ms 2	Funeral	11. Marital Status		edent Ever in U.	S. 13.	Was Decedent of H			ecify Yes or No-	14. Ra	ace - Ameri ack, White,	can Indian,
5	or Ite		1 ☐ Never Married 2 🔀 Marri	ed 1 Yes	2 No		1 ☐ Yes 2 ☐ YNo			Tilodit, oto.)	Spec		, 616.
3	ral",	b	3 ☐ Widowed 4 ☐ Divorced	Year or D	Dates: KOREA	AN	TE TOS ESANO	Ороси	.,,.		Spec	"y BL	ACK
5	72 n natu dical	Completed	15. Decedent (Specify only highes	's Education t grade completed)		(Give	dent's Usual Occup kind of work done	durina m	nost of work	ing	16b. Kind of	Business/Ir	ndustry
7	Mer.	du	Elementary/Secondary (0-12)	College (	1-4or 5+)		DO NOT use retire	•					
7	illed within 72 hours after death with the Maryland Hygiene, than "natural", or Items 23a or 28a-f show the than "hatcal Examiner must be notified at	S					NAVY CHII	T	Ab a da Mana	- /First Middle		CTRON	ICS
	tal H d oth	Be	17. Father's Name (First, Middle,	,				18. MC		e (First, Middle, i		•	
7	s 1 and 2 should be nied within 12 hours after death with the Maryla f Health and Mental Hygiene. Hem 27 is marked other than "natural"; or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at	은	ROBERT		THAXTON					ETTA		SELL	
= .	2 sh and Ism raum	ľ	19a. Informant's Name/Relationsh			ł	ng Address (Street						
2	hand health tem 27	l l	EDITH THAXTO	N/WIFE	look D		4 NEW ACA	ADIA		UPPER M	ARLBOR 20c. Location		
5	Pages I nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from	1 0	emetery, cre	matory or other pla	ice)		Date	20c. Location	1 - City or 1	own, State
	ment:	١.	4 □ Donation 5 □ Other (S	pecify)			CREMATOR		7-7-			RDALE	
Dall	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service	Licensee Ambus	MOC MOC	0091	2. Name and Addre CHAMBERS 5801 CLEV	FUNI FUNI FLAN	cility ERAL F ND AVE	HOME & C	REMATO RDALE,	RIUM,	P.A 20737
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death								Approximate Interval Between
Ė.	hysician		Immediate Cause (Final		REAS CAN	ICED							Onset and Death  16 MONTHS
	/Medical		disease or condition resulting in death)	a	(or as a consequ								10 HONTHS
	Examiner	Н										- 1	
100		Je.	Sequentially list conditions, if any, leading to immediate	Due to	(or as a consequ	uence of):							
	cutec id ansi	Examiner	Cause (Disease or injury that initiated events	C									
Ś	an ar an ar rrial-t	ŭ	resulting in death) Last	Due to	(or as a consequ	uence of):							
,0070	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		d									
Ď	ng ph ng ph as tl	Med	IF FEMALE:										
20	th ce tendi r use	Physician/Med	23b. Was decedent pregnant		utcome pf pregna birth 2□Feta		⊒Ectopic pregnand	су				Date of delivery	very Day Year
	e dea he at ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg 9□Unki	nant at time of d	eath 5	Other (specify)					VIOITAT	Day Tour
	at the I by tl	h	9 Unknown			Maria de Maria		'- D		non Did to		merikuta ta	the cause of death?
ń	es th igned		Part II. Other significant condition	-	death but not rest	ulling in the c	maenymy cause gr	vennra	111 1.		es 2∏No		
COLUS,	equil	ted	LUNG CANCE	<u>x</u>									Journal of the Common of the C
ָ ט	law l as be	ble								24a. Was autop	sy	prior to c	topsy findings available ompletion of cause of
	The ate h page	Completed by								perfor 1∐ Yes	med? 2 No	death? 1 ☐ Yes	2 No
2	sian: ertific ctor,	Be (	25. Was case referred to medical examiner?						ace of Deat	th (Check only o	ne)		
2	hysic his ce I dire	2	1 ☐ Yes 2 No	Hospital: 1	] Inpatient 2 🗆	ER/Outpatie	III JUDON		Nursing H	ome 5 Resid	ence 6 □C	Other (Spec	cify)
5	ng P fter t nera		27. Manner of Death 1 X Natural 5 ☐ Pendin	/4.4 -	e of Injury nth, Day Year)	28b. Time o Injury	of 28c. Inju	ury at ork?		28d. Describe h	ow injury occ	urred	
5	endil sath. or: A he fu	atic	2 ☐ Accident investig	gation				Yes 2	! □ No				
<u> </u>	or Attending Physician: tter death. Director: After this certifica in by the funeral director, i	Certification:	3 ☐ Suicide 6 ☐ Could I 4 ☐ Homicide determ	ined Zoe. Flat	ce of injury - At ho ding, etc. <i>(Sp</i> ec <i>if</i>	ome, farm, st fy)	reet, factory, office	:		28f. Location (S City or Tow		mber or Ru	ral Route Number,
2	ital c Irs aff ral D												
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier (Check only 2 Medical one)	ng Physician: To the Examiner: On the and ma	ne best of my kno basis of examina nner stated.	wledge, dea ttion and/or it	th occurred at the investigation, in my	time, date opinion,	e and place death occu	, and due to the c rred at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
	o the	Med	29b. Signature and title of certifie	1-/1	1	1	29c. Licen	se numb	er		29d. Date sig	ned (Month	n, Day, Year)
	PSF O		<b>&gt; &gt; &gt; &gt; &gt; &gt; &gt; &gt; &gt; &gt;</b>	(1/CN)	× /( /		12	c3,j	2_		4/2	/c8	
	0	1 9	30. Name an address of person	who simplified car	ise of death (Item	n 23a) (Tvne		-0			-//		
		ka 13		ATZEN, M.			OODYARD I	RD.	CLINT	CON. MD	20735		
	Sta	ate	31. Date filed (Month, Day, Year)	00.4	6 1 1 1 0	A			OUTIN		20133		
	Registi		JUL 08	2008	Hegistrar's Signa	4 Ap	anti						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Weese Richard HARPER 9:05 A M July 02 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Moran Manor Nursing Home Allegany Westernport If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2□F Month Day Year Director 232-22-1105 91 Beverly, WV Usual Residence of Decedent within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits WU Mineral "natural", or Items 23a or 28a-f shidical Examiner must be notified 1 ☐ Yes 2 No Director Springfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Lot 19, South Potomac Forest 26763 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1€1Yes 2□No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 □ Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Building Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grover Cleveland Weese Dovie Mae Kerens Weese ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 220, Springfield, WV 26763 Maxwell Weese 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot once. 07/05 **Q** Burial 2 ☐ Cremation 3 ☐ Removal from State Weese Cemetery Beverly, West Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2008 22. Name and Address of Facility Boal Funeral Home 111 Church Street. 21. Signature of Funeral Service Licensee Westernport MD 23a. Part1. Enter the disease, or comshock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Endstage years /Medical Due to (or as a co F equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): requires that the death certificate be executed Due to (or as a consequence of): Box 68760. 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Chknown has been The law 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 221110 this certificate 1□ Yes Division or Vital the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Salursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Injury 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled in Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 721244 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAN, 4 BROADWAY, FROSTBURG, MD 21532 JESUS

DHMH 17 Rev 1/2001

State

Registrar

2 Registrar's Signature

2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Operation (Certificate of Death)

			For State Registrar	State of M	laryland	d / Depa <i>Cei</i>	artment of F rtificate of	lealth and <i>Death</i>	Mental Hy	giene 0	08	23642
	Physici /Medic		1. Decedent's Name (First, Middle HELEN	, Last)		WH	ITE		2. Date of De Month	Day	Year	3. Time of Death 23 25P M
1	Examir		4a. Facility Name (If not institution Shady Grove A			ital	4b. City, Town, o	r Location of Dea	ath	4c. County MONT	of Death	RY
Ī	Funeral Director		5. Social Security Number 434-32-0040		Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hr Hours Mir		, 1918	9. Birthpla Country Lou	ace (State or Foreign y) Isiana
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Macical Experience mass the action of once.	To Be Completed by Funeral Director	10e. Street and Number  102 Sharpste  11. Marital Status  1 □ Never Married 2 □ Marri  3 □ Wildowed 4 □ Divorced  15. Decedent (Specify only highes  Elementary/Secondary (0-12)  12th  17. Father's Name (First, Middle, I  Charles Rar  19a. Informant's Name/Relationst  Mary Adams  20a. Method of Disposition  1 □ Burjan 2 □ Cremation	12. Was Deceden Armed Forces   1   1   4   2   2   1   4   7   2   1   4   7   2   1   4   7   2   1   4   7   2   1   4   7   2   1   4   7   1   4   7   1   7   7   7   7   7   7   7   7	t Ever in U.S No : : :5+)	16a. Dece (Give life. I	Nas Decedent of Fifes, specify Cubrick of Power 1 Domesting Address (Street	20878  dispanic Origin? ( an, Mexican, Pue  Specify:  nation during most of we  C  18. Mother's Na  Let  and Number or R  cead La	(Specify Yes or No orking Aircan, etc.)  orking  ame (First, Middle, hia Ric aural Route Numb. ne, Gai	10g. Citizen of V U  14. Rac Blac Specify  16b. Kind of Bu  Maiden Surnam Chardso er, City or Town,	What Countre S.A.  De - Americal Ck, White, etc.  WE Black  USINESS/Indu  HOME  De De De De De De De De De De De De De D	d. Inside City Limits  1 Yes 2 No  y?  In Indian, c.  Ck  Instry  Code)  MD 20878
No.	ifficate be executed  g physician and important language as the burial-transit any injure and injure any injure and injure any injure and injure any injure and injure any injure and injure any injure any injure and injure any injure and injure any injure and injure any injure and injure any injure and injure any injure and injure and injure any injure and injur	Examiner	4 Donation 5 Other (St. 21. Signature of Funeral Service) 23a Part 1. Enter the disease, or shock, or heart failule. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	complications that cause only one cause on each  a. ASPID  Due to (or as	ed the death. line. 2 A T I	oo not ent	Name and Addre	ss of Facility S lashing	NOWDEN	FUNERA Rockvi	L HOM	ME , P.A. MD 20850 Approximate nterval Between Donset and Death
P.O. Box	es that the death cer igned by the attendin be detached for use a	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditio	9	2 ☐ Fetal at time of de	death 3 Death 5 D	Ectopic pregnanc Other (specify) _			Mo	ribute to the	cause of death?
Hec Hec	The law ate has t	To Be Completed	25. Was case referred to medical examiner?	MCARI F	AICU.		t 3□ DOA Oth	or:	24a, Was	an 24b. ssy rmed? 2 No	Were autops prior to comp death? 1 □ Yes 2	
Division of	ipital or Attending ours after death. Ieral Director: After filled in by the funer	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifler  27. Manner of Death 5 Pending investig 6 Could n determi	ation ot be 28e. Place of In	njury - At honetc. (Specify)	)	M 1 □	y at ⟨? Yes 2 □ No	28d. Describe I	now injury occurr Street and Numb vn, State)	red oer or Rural I	Route Number,
	To the Hos within 24 hc To the Fun completely	Medical	(Check only 2 Medical E	Examiner: On the basis and manner s	of examinati	on and/or in	vestigation, in my c	pinion, death oc	curred at the time,	date and place,  29d. Date signe	and due to t	he cause(s)
			30. Name and address of person v	·		, , , , .	,	OR INT	ROCK	VILLE	MD 2	5850

State Registrar 31. Date filed (Month, Day, Year) 2008

fresh

32. Segistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIP ## 26, Der VERB. (881, 7/7) (8, 18)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 111 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 💢 F Director Pennsylvania 185-14-8135 July2,1922 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show must be notified at 1X Yes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 items 23a U. S. 695 Hilltop Road-Orchard Beach A. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced "natural" Completed and Mental Hygiene.
Is marked other than "natur raumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Spiker Anna Gardner ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 695Hilltop Road-Orchard Beach, Baltimore permit. Pages 1 and 2: Department of Health a Important: If item 27 Is any Injury or other traugnce. Beverly J. Hoffman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State Horner-Mt. Tabor Cem. 7-4-08 | Stoystown, PA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 21. Signature of Funeral Service Licensee muhael Road, Baltimore, Maryland21214 6009Harford 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequenc Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as I IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ ▼ o s certificate has be lirector, page 2 s autopsy Yes 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred : After t 28c. Injury at Work? 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. Accident within 24 hours after dear To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) J.Meglical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29d. Date signed (Month, Day, Year) Haurin st. Ba therson who completed cause of death (life Tha) (Type, P 5 30. Name and address guillake 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUL 2 2 2008 Registrar

De-05366 Dean Martin Anthor	State of Maryland / Department of Health and Mental Hygiene
	1- For State Certificate of Death Reg. No. 2008 236
Physician/	1 Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death
Medical Examiner	Dean Martin Anthony  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
. )	1100 Bolton Street Apt. 217  Baltimore City  NA
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	215-86-4778 1XM 2 F 44 Yrs. Months Days Hours Min. July 6, 1965 Country) MD
á:	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limi
or ihow a	MD NA Batimore City 1X Yes 2 1
the Maryland a or 28a-f sh tified at once Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
h the 1 23a or notified	1100 Bolton Street Apt. 217 21201 USA
er death with or items 23. must be no Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
fter de F.ori	
nours after a standard standar	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
36 in 72 h han "r dical E	Eiementary/Secondary (0-12) College (1-4 or 5+)  N/A  Disabled  N/A
5-0036 ed within 72 hours tygiene. other than "natu like Medical Exan Completed	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
1215 be file ontal H irked of	Alexander Spirery Bette J. Anthony
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
and 2 and 2 fealth 3 tem 2 traum	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
nore ages I ant of F at: If i	1 Burial 2 Cremation 3 Removal from State Metro Crematory 7/23/08 Catonsville, Marylar
Baltimo permit Pag Department Important: injury or ot	4   Donation 5   Other Specify:  . unature of Funeral Service Licensee  22. Name and Address of Facility
	Solution of Funeral Service Licensee  22. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  28. Name and Address of Facility  28. Name and Address of Facility  29.
Physician /Medical	failure. List only one cause on each line.
xaminer	Immediate Cause (Final disease or condition resulting in death)  a Chronic Alcoholism  Due to (or as a consequence of):
	Sequentially list conditions, b
nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c.
red Insit	events resulting in death) Last  Due to (or as a consequence of):
box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit Physician/Medical Ex	d. UNPENDED AMENDED
Box 68760, e death certificate be the attending physic ed for use as the bur hysician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
certiff certiff anding ste as t	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year  Pregnant at time of 5 Other (Specify)
Box e death the attr	1 Yes 2 No 9 Unknown 9 Unknown
cords, P.O. Box 68760, aw requires that the death certificate be that been signed by the attending physic 2 should be detached for use as the bur pleted by Physician/Mec	
Records, P.C. The law requires that freate has been signed by page 2 should be detered by	24a. Was an   24b. Were autopsy findings availa
COTC	autopsy prior to completion of cause of performed? death?
tal Reco	25. Was case referred to medical 26. Place of Death (Check only one)
Division of Vital Records, P.O. Isal or Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach brification: To Be Completed by P	examiner?
n of Viiing Physiing	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  28d. Describe how injury occurred
ivisior or Attend after death Director: I in by the	Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, C
Division or spiral or Attending rours after death. neral Director: After filled in by the fune. Certification:	3 Suicide 6 Could not be determined (Specify)  Suicide 6 Could not be determined (Specify)
To the Howithin 24 To the Fu Completely	Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
_ ×	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  O.C.M.E.  July 14, 2008
	3 No fire and address of person who completed cause of death (Item 23a)
3	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State	
Registrar DHMH 17 Rev 1/2001	
PRIME 17 Rev 1/2001	ORIGINAL

08-05474 Richard A. Anderson

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 23645

Chard A. Ande		1- For State		ficate of				eg. No.	3. Time of Death
Physicia ledical Exami	_	Decedent's Name (First, Middle,L     RICHARD ANS					Month July 17, 26	Day Year	0018 hrs
	iiei	4a. Facility Name (if not institution, g		41	o. City, Town, or	Location of Dea		4c. County of D	eath
		7617 Arbory Court			Laurel			Prince Ged	•
Funeral		Social Security Number 6.	Sex 7. Age (In yrs. last	t birthday)	If Under 1 Yea			th(MM/DD/YYYY) 9	. Birthplace (State or oreign
Director		408-02-0527	X <sub>M 2</sub> F 53	Yrs.	Months Day	s Hours M	in. 10/20		Country) Alabama
		Usual Residence of Decedent			·				10d. Inside City Limits
w any	i	10a. State 10b. County	1	own or Location	n				1 Yes 2 No
Aaryland 28a-f show 1 at once.	힏	Maryland Prince	e George's Laur	rel	10f. Zip Code		1	0g. Citizen of What	2121
th the Maryland  23a or 28a-f sho	Director	7617 Arbory Cour	-+		2070	7	- [	U.S.A.	,
ith th		11. Marital Status	12. Was Decedent Ever in U.S.	. 13. Was			Specify Yes or No		merican Indian, Black,
eath w items ust be	Funeral	1 Never Married 2 X Marri	ed Armed Forces?	If Ye	s, specify Cubar	n, Mexican, Pue	to Rican, etc.)	White, e	tc.
ffer d	by F.	3 Widowed 4 Divorce	1 XXYes 2 No ed If Yes, Give Year 1973-198	33 1	Yes 2XX No	specify:		Specify:	White
ours a		15. Decedent's Education (Specify	, , , , , , , , , , , , , , , , , , ,		s Usual Occupa st of working life			16b. Kind of Busin	ess/Industry
16 n 72 h nan "r ical E	olete	Elementary/Secondary (0-12)	College (1-4 or 5+)		Associ			Potail	Furniture
.0036 I within 72 giene. her than	Completed	Grade 12 17. Father's Name (First, Middle, La	est)	Sales			me (First, Middle,	Maiden Sumame)	
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212 ould b i Meni in mari	To E	19a. Informant's Name/Relationship						mber, City or Town,	State, Zip Code)
MD d 2 sho lith and n 27 is		Sheila I. Anders			_			Maryland	20707
Imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Internstrate anter friem 27 is marked other than "natural", or other traumatic event, the Medical Examines.	H	20a. Method of Disposition  1 Burial 2 XXCremation	3 Domougl from State Cre	ematory or oth			Date	20c. Location - Ci	
Page:		A Donation 5 Other Spec	West	- 1					n, Maryland
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other I injury or other traumatic event, the Med		21. Signature of Funeral Service Lic	censee PER DVR MO1103	22 N	me and Addres naldson	s of Facility Funera	1 Home,	P.A.	1 00505
		Janice L.  23a. Part I. Enter the disease, or co	Zook 7770					el, Maryl rest. shock. or heart	
Physician /Medical		failure. List only one cause on	each line.						Between Onset and Death
xaminer	W 1	Immediate Cause (Final disease or condition resulting in death)	a. Propoxyphene &  Due to (or as a consequence of):		inopnen	intoxi	cation		
		Sequentially list conditions,	b						
	miner	if any, leading to immediate	Due to (or as a consequence of):						
	•	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	:					
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), be exe ician a	Medical	X UNPENDED	X AMENDED 23a,27,2 Iten#21,per	rFH,0881	,7/23/08,1	G882 87 WS	7/08 TT		
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed easth.  Geath.  The law specificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transition of the control of the	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregna	ancy		Ectopic pre	nnancv	23d. Date of de Month	elivery Day Year
certil certil ending use as	/sician/	past 12 months?	4 Pregnant at time of deat		ner (Specify)		9.14.19		
Bo, death the att	Physi	1 Yes 2 No 9 Unkno	9 OTRHOWN						
of Vital Records, P.O. Box 687 and Vital Records, P.O. Box e887 approximan: The law requires that the death certificate has been signed by the attending parental director, page 2 should be detached for use as the	by PI	Part II. Other significant condition	ns contributing to death but not res	sulting in the u	nderlying cause	given in Part I.			robably 4 Unknown
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Vital Rec Vital Rec hysician: The l this certificate I	Be (	25. Was case referred to medical examiner?	Hospital:			Other Nu		Residence 6 ✔	Other: Seene
F VI Physical direction	<sup>2</sup>	1 ✓ Yes 2 No 27. Manner of Death	I Inpatient 2 L	ER/Outpatient 28b. Time of Ir		ury at Work?	rsing Home 5	how injury occurred	
h of hiding Ph	ion:	1 Natural 5 Pendin	(Month, Day,Year)			Yes 2 X No	unk	,,,	
Division tal or Attendii ra after death.	Certification:	2 Accident Investig	gation // 17/00 File		t, factory, office	building, etc.	28f. Location	(Street and Number	or Rural Route Number, City
Divis Divis pital or At ours after d	ertif	3 Suicide 6 X Could redeterming					or Town, Laure	State) 7617 A	rbory Ct.
Hospi 24 hou Funer rely fil		29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge	e, death occur	red at the time, o	date and place,	and due to the cau	use(s) and manner a	s stated.
Division  To the Hospital or Attention within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Exami	ner:On the basis of examination and manner stated.	d/or investigat	ion, in my opinio	n, death occurre	ed at the time, date	e and place, and due	e to the cause(s)
E 3 E 8	Me	29b. Signature and title of certifier	<i>α</i> Λ			ise number			(Month, Day, Year)
		a andurt	em)		0.0	.M.E.		July 17, 200	o 
7			ho completed cause of death (Item 2		Ctract Date	imora MD G	1201		
U			sistant Medical Examiner		Street, Balt	imore, MD 2	1201		
S Regis	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	LOGAL	5-0				

State of Maryland / Department of Health and Mental Hygiene 008 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 6:55 a M NATHEN MATTHEW ARREDONDO July 10, 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth
(Month, Day, Year)
July 9, 2008 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 9 1)**∑**}M 2□ F Yrs. N/A Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Tes 2 No MD Director Anne Arundel Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20724 U.S.A. 231 Red Clay Road, Apt. 302 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. Mexico / 1 X Never Married 2 Married XXYes 2□ No Specify: Specify: Completed by El Salvador White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Essau G. Arredondo Lizeth Joya 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Laurel, Maryland 20724 231 Red Clay Road, Apt. 302 Essau G. Arredondo father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 7/15/2008 Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee M00770 | 313 Talbott Avenue Laurel, Maryland 20/07 23a. Part1. Enter the disease, or a implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hand failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Da Failure Due to (or as a consequence of): tolmonar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examiner Syndrome 100 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗍 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 22 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 Z No 1 Inpatient 2 ER/Outpatient 3 DOA ۵ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manper of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 [7] Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 07-10-08 0031315 welleste MIDa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, Maryland 400 West 7th Street, Fabio Olarte, M.D. 31. Date filed (Manth Day Year) 2008 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

**Funeral** 

Director

item 27 is markad other than "natural", or items 23a or 28a-f show othar traumatic evant, the Medical Examinar must be notified at

al Hygiene.

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, Important: If item 27 Is marked other any injury or other trailments.

Physician

/Medical

Examiner

physician and s the burial-transit

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page 2

has

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After

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within 24 hours after death To the Funeral Director:

Hospital or Attending

The law requires that the death certificate be executed

P.O. 1

Division of Vital Records,

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

08-05442 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend I tem 8 per Th. 2889 03723/09dhb Zachery Lee Ashby 2008 23647 1- For State Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 15, 2008 1515 hrs **Medical Examiner** Zachery Lee Ashby 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Prince Georges Hospital Center Cheverly 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 11/10/1961 Foreign Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** 11/10/1961 Months Davs Hours Director Country) 217-82-0314 -11ml 1 M 2 F 46 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No 28a-f show Washington District of Columbia 10f. Zip Code 10g, Citizen of What Country? s 23a or 28a-10e. Street and Number 4660 Martin Luther King Jr Ave SW 20032 United States the with 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nomust be Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 X No Yes 9 Yes 2 X No specify: Specify: Black If Yes, Give Yeer Widowed 4 Divorced the Medical Examiner 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036
pernit. Pages I and 2 should be filed within 72 hc
Department of Health and Mental Hygiene.
Important: If item 27 is most Elementary/Secondary (0-12) College (1-4 or 5+) DC Metro Twelth None Bus Driver System item 27 is marked other traumatic event, the Me 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Haywood E. Ashby Eva Staley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Haywood Alvin Ashby/Brother 139 Foxtree Dr, Glenn Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition nt: If it crematory or other place) July 25, 1 Burial 2 XXCremation 3 Removal from State 2008 Riverdale Maryland Donation 5 Other Specify Riverdale Park 22. Name and Address of Facility 21. Signature of Funeral Service Licens Robert G. Mason Funeal Home Inc 1661 Good Hope Rd SE, Washington DC 20020 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** een Onset and failure. List only one cause on each line /Medical Death a. Cerebellar Hemorrhage Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of) b. Hypertensive Atherosclerotic Cardiovascular Disease Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to for as a consequence of a (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical #8 per Fh G881 7/23/08 TT e attending physician a for use as the burial -UNPENDED X AMENDED the Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Day 2 Fetal death Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown by the a 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed of Vital Records, 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? performed? ✔ Yes 2 2 No 1 Yes No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other 4 Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 DOA this 1 V Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work After 27. Manner of Death Certification: 1 V Natural Division Yes 2 death. Pending Director: the 2 Accident Investigation þ 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. hours after 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific O.C.M.E. July 17, 2008 me/and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner

Registrar
DHMH 17 Rev 1/2001

**OCME 2006** 

State

OCME

31. Date filed (Month, Day, Year)

ORIGINAL

32 Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	Otato or war year	-	tificate of L			3. No. 2008	23648
	Physici	an	Decedent's Name (First, Middle, La.	st)			}	. Date of Death Month	Day Year	3. Time of Death
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	Examir	ier	4a. Facility Name (If not institution, giv GILCHRIST HOSP)	,		4b. City, Town, or			4c. County of Deat	
	Funeral		5. Social Security Number 6. S		. last birthday)	TOWSO		. Date of Birth	BALTII	hplace (State or Foreign
	Director			□M 2 X F 95	***	Months Days	912	Country) POLAND		
	pr ,		Usual Residence of Decedent							
	arylar <b>show</b>	-	10a. State 10b. County		ity, Town or Loc					10d. Inside City Limits 1 1 Yes 2 □ No
	he Mi	ectc	MD N/	Α	BALTIMO					
	with the	ä	10e. Street and Number	TO 11151115 #00		10f. Zip Code		100	g. Citizen of What Co	untry?
	eath rs 23	by Funeral Director	7111 PARK HEIGH	12. Was Decedent Ever in U		/as Decadent of His	21215	h. Van ar Na	USA 14. Race - Ame	vison Indian
<b>,</b>	fter d riten insc	Fun	1 ☐ Never Married 2 🔏 Married	Armed Forces? 1 □Yes 2 XNo	J. G. V	Yes, specify Cubar	spanic Origin? (Speci n, Mexican, Puerto Ric	can, etc.)	Black, White	
036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dien Evaninat he notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	□Yes 2XINo	Specify:		Specify: WH	ITE
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2	led w Hygie her ti	ပိ	17. Father's Name (First, Middle, Last)			BOOKKEEPE			INSURA	NCE
and	l be fental feed of	Be	HARRY		GOODMAN		18. Mother's Name (F	rirst, iviladie, ivia		HNITZER
Z	should be and Mental is marked caumatic even	은	19a. Informant's Name/Relationship (			Address (Street a	nd Number or Rural F	Pouto Number (		
Z	and 2 sealth a n 27 is ser trau		MILTON ALBERT		- 1		IGHTS AVEN			
Baltimore, Maryland 21215-0036	프트		20a. Method of Disposition	20b.	Place of Dispos		Date		C. Location - City or	<u>-</u>
m	permit. Pages Department of Important: If it any injury or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	HAR S		07/22/	2008	OWINGS M	TILS. MD
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<u>m</u>	89728		Jolul !!	- Nemira	3	3900 REIS	TERSTOWN R	0AD - P	IKESVILLE	, MD 21208
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and.	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	-				
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	ng ph as th	Med	IE EEMALE.							
Вох			IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy			23d. Date of deli	
0	the a	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown		Other (specify)			Month	Day Year
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Division of Vital Records,	ician: Th certificate rector, pag		25. Was case referred to medical				26, Place of Death (0		No 1 □ Yes	2 <b>2</b> No
$\leq$	S S S	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	Othou			ce 6 Tother (Spec	city) HOSPICT
0	ding Ph h. After thi funeral	L:u	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work?			injury occurred	1197 110 Spile E
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	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	(Check only one)	ysician: To the best of my kniner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my op	e, date and place, and inion, death occurred	at the time, date	ise(s) and manner as e and place, and due	to the cause(s)
	o the	Me	29b. Signature and title of certifier	and marmor otated.		29c. License	number	290	I. Date signed (Month	n, Day, Year)
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	4	+	30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, P	rint)	6 /			
	. (		30. Name and address of person who of Tason Black M 31. Date filed (Month, Day, Year)  JUL 2 3 20	D.6565 MON	My Char	Clas St, S	vite 209	toa	soa m	021204
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Albert, Fay 7/20/08 955.

			For State Registrar		State	of Maryla	nd / Dep		t of H	ealth a	and M		giene Reg. No.2	008	23649	
	Physic /Medi			NALD F	RED BROW							2. Date of De Month JUNE	<b>26</b>	2008	3. Time of Death <b>7:31AM</b> M	
	Exami	ner	4a. Facility Name (					4b. City,		Location of	of Death		4c. Co	unty of Death TALBO	T	
	Funeral	7 1 1	5. Social Security		HAELS RO. 6. Sex	_	. last birthday,	If Under	1 Year	If Under		8. Date of Bir (Month, Da	th		lace (State or Foreign	
	Director		248-74-0 Usual Residence of		<b>™</b> M 2□F	63	Yrs.	Months	Days	Hours	Min.	MAY 22	,1945	ALAB	AMA.	
	yland how at		10a. State	10b. County		10c. C	ity, Town or L							1	0d. Inside City Limits	
MD TALBOT EASTON  10e. Street and Number  25904 ST. MICHAELS ROAD  11. Marital Status  1  Never Married  12. Was Decedent Ever in U.S. Armed Forces?  1  Never Married  1  Never Married  1  Never Married  1  Never Married														1 ☐ Yes 2 <b>X</b> No		
	106. Street and Number 216												10g. Citizen	of What Cour	itry?	
	death ms 23 musi	nera	23904 S 11. Marital Status	T. MICH	12. Was De	ecedent Ever in l	J.S. 13.	Was Dece			igin? (Sp	ecify Yes or No	)- 14.	Race - Americ		
980	MD TALBOT EASTON  10a. State 10b. County											Rican, etc.)		Black, White, ecify: WHI		
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	Hygi Other ent, tl	Be Co	17. Father's Name	e (First, Middle, I	ast)	7					er's Name	ə (First, Middle	, Maiden Su	rname)		
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Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of F					2. Name ar	od Addres	s of Facili	NBEI:		nam fi	INERAL	HOME PA	
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3760,	eath certificate be executed attending physician and for use as the burial-transit	ical Examiner	Sequentially list c if any, leading to it cause. Enter Und Cause (Disease o that initiated even resulting in death)	mmediate lerlying or injury ts Last	С	o (or as a conse										
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Division or	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi	nod   200. Fld	ce of injury - At I Iding, etc. (Spec	4 7 7 7 4								+	
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	o the o the omplet	Medical	one) 29b. Signature an	of the of certifier	and ma	anner stated.				e number				igned (Month,		
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T	Sta Regist	ate rar	31. Date filed (Mo	nth Day Year)	2008	Registrar's Sign	nature		)	- 1						

DHMH 17 Rev 1/2001

08-04946 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Tyrone Boyd, Sr. State of Maryland / Department of Health and Mental Hygiene 2008 23650 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day June 26, 2008 1809 hrs Medical Éxaminer Tyrone Boyd Sr 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Prince George's 1100 Owens Road #604 Oxon Hill 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign Min Director Countr Wash, DC 1X M 58 578-66-8341 2 F 6 1950 March Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location s 23a or 28a-f show notified at oner. 1 X Yes 2 No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at one. Prince Georges Oxon Hil Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1100 Owens RD 20745 ted States Funeral 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married Yes 2 X No Specify: Black 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 No specify: þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Computer Technician 12th Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alonzo Boyd alonia Payton ٩ 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tyrone Boyd Maryland 20770 Bird Ln Greenbelt 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Ressurection 7/03/2008 Clinton, MD Donation 5 Other Specify: 22. Name and Address of Facility
Wesley Chavis III Funeral Service INC. 21. Signature of Funeral Service Licensee 10684 Southern MD BLVD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Cardiomegaly Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical attending physician for use as the burial UNPENDED **AMENDED** Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ģ 1 Yes 2 No 3 Probably 4 V Unknown Siezure disorder Completed 24b. Were autopsy findings available 24a Was an Diabetes Mellitus prior to completion of cause of autopsy this certificate has I performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Division of Vital Other<sub>4</sub> DOA Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient Inpatient 1 V Yes No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: 1 V Natural Pending Yes 2 No Director: 24 hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide To the Funeral Di determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. June 27, 2008

State Registrar Chief Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

OCME

David Fowler M.D.

31, Date filed (Month, Day Ye

111 Penn Street, Baltimore, MD 21201

			1 - For State Registrar	State of Marylan	id / Dep <i>Ce</i>	artment of H rtificate of I	lealth and	Mental Hy	giene, Reg. No.	2008	23651
	500	-	Decedent's Name (First, Middle, La			Timodio or 1		2. Date of De			· 3. Time of Death
- 61	Physici /Medi		Lettie Mae	Blount				June 30	Day 200	Year	10:30 A <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deat			County of Death	
			Manor Care Nurs	ing Home		Chevy C			Me	ontgome	ry
1	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th ay, Year)	9. Birth	place (State or Foreign intry)
	Director		238-26-7757 Usual Residence of Decedent	83	Yrs.			July 2	1, 19	24 Nor	th Carolina
	land ow at		10a. State 10b. County	10c. Cit	y, Town or L	ocation					10d. Inside City Limits
	with the Maryland a or 28a-f show t be notified at	ţċ	District of Co	alumbio	Mag	hington					1 Yes 2 No
	th the	Director	10e. Street and Number	TUMDIA	was	10f. Zip Code			10g. Citize	en of What Cou	intry?
	th wit	alD	1377 Downing St	reet, NE		20018			Uni	ted Sta	tes
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	Specify Yes or No to Rican, etc.)		4. Race - Ameri Black, White,	can Indian,
36	ours after death vall, or items 23s	by Fı	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give		1 ☐ Yes 2 HNo	Specify:	. ,			lack
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	pe pe	15. Decedent's E	Year or Dates:	16a Dece	dent's Usual Occupa	ation		16h Kin	d of Business/Ir	advanta.
15	iin 72 n "na Nedic	plet	(Specify only highest gr	ade completed)	(Give	kind of work done of DO NOT use retired	furing most of wo	rking	lob. Kind	1 Of Dusiness/if	loustry
212	filed within Hygiene.  ther than " int, the Mec	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Depa	rtment Sto	ore Mana	ger	Pı	rivate	
р	al Hyi l othe	Be C	17. Father's Name (First, Middle, Last	)			18. Mother's Nar	me (First, Middle	, Maiden S	urname)	
Maryland	should b ind Menti marked umatic e	To	James Avent				Lan	nie Hint	on		
ar	2 sho and is ma		19a. Informant's Name/Relationship (	**		ng Address (Street a					
	s 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical	1 3	Greta Faison - 1			- 7th St	reet, NE				
Baltimore,	it of h	1 3	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, cre	osition (Name of matory or other place	· i	Date		ation - City or T	•
Ħ	it. Pa rtmer rtant: njury		4 Donation 5 ☐ Other (Special			oln Cemete					
Ba	permit. Pages Department of Important: If it any injury or once.		21. Signature of Femoral Service Lice	Townst		2. Name and Addres					
			23a. Part Lanter the disease, or com shock or heart failure. List only	plications that caused the death	n. Do not en	ter the mode of dying	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		SOPH	IAGEAL	CA	NCE	R		Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq							
	21111111111	_	Sequentially list conditions,	b							
	led list	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	uence of):						
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):			<del></del>			· · · · · · · · · · · · · · · · · · ·
68760,	e be e sician buria	dical			,						
	4			u							
Box	death certific e attending p d for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna 1□Live birth 2□Feta		Tratagia			23	3d. Date of deliv	very
	0 0 0	Sicie	in the past 12 menths? 1 ☐ Yes 2 ☑ No	4□Pregnant at time of d		∃Ectopic pregnancy ∃Other <i>(specify)</i>				Month	Day Year
P.0	requires that the de sen signed by the a tould be detached i	Phy	9 Unknown					-			
	res th signed be do	by	Part II. Other significant conditions	ontributing to death but not resu	alting in the u	nderlying cause give	n in Part I.			0	the cause of death?
orc	w require been sig should b	ted						1 🗆	Yes 2 <b>∑</b>	No 3∐Pro	bably 4 □Unknown
Records,	as 2	Completed						24a. Was auto	psy	prior to co	opsy findings available ompletion of cause of
	ician: The certificate ha ector, page					. <u> </u>		perfo 1□ Yes	rmed? 2 No	death? 1 ☐ Yes	210 No
or Vital	Physician: this certific	Be	25. Was case referred to medical examiner?	Hospital:		othe		ath (Check only o			
o	Phys r this ral di	<u>د</u> ا	1 Yes 2010 27. Manner of Death	1 Inpatient 2 28a. Date of Injury	ER/Outpatier 28b. Time o	IL SELECT	4 Z Nursing F	lome 5 ☐ Resi 28d. Describe			(fy)
Division	Attending r death. ector: After by the fune	ţi	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work	? ∕es 2 ∐ No	Zou. Describe	now anjury	occurred	
/Si	Atter r deat ector by the	lica	3 Suicide 6 Could not be determined	28e. Place of injury - At ho			-	28f. Location (	Street and	Number or Rur	al Route Number,
Ö	s afte	Certification:	4 [] Hornicide	building, etc. (Specify	<i>(</i> )			City or To	vn, State)		
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral dir		(Check only 2 Medical Exar	ysician: To the best of my kno niner: On the basis of examina	wledge, deat	h occurred at the tim	ne, date and place	e, and due to the	cause(s) a	ind manner as	stated.
	the hin 24	Medical	one)	and manner stated.							
	S o i	-	29b. Signature and title of certifier	In Pous	VL 5	29c. License	57/1	-4	29d. Date	signed (Month,	Vay, Year)
	7	-	OO News and 11				,,	1		1010	1
	12/		30. Name and address of person who Dr. Trvong Bao 9		, , , , .		1 a MD				
	Sta	te	31. Date filed (Month, Day, Year)				.re, 1/11/				
	Registr	_	JUL 1 0 2008	32. Registrar's Signa							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 19b, perFH G 882 8/1/08 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 23652 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 7:34 P M JUL 2008 /Medical 4a. Facility Name (If not institution, give street and num 4b. City Town, or Location of Death 4c. County of Death Examiner Medical Baltinean 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 4 9 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** <sup>Year)</sup> 1934 Days 1 ☐ M 2 🔀 F 74 240-48-6231 Director NC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits at or items 23a or 28a-f sh miner must be notified MD XXYes 2 No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1017 Bonaparte Avenue 21218 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes A No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: 3 Widowed 4 Divorced Black Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping 10th Marriott Hotel permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, ? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Belton McCoy Stella 2 McDonald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ramblewood 1210 Ravenwood Road Baltimore, MD 21239 <u> Ardella Miles-daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Removal from State Zion Cemetery 7/25/08 4 Donation 5 Dother (Specify) Baltimore MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST Blad 1101 E. North Avenue Baltimore, MD 21202 Wans 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician nevilloria /Medical Due to (or as a consequence of) End Stage renal disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner Sarcol burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 pronths? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient ٩ 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No **Director**: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier and manner stated 29c. License number 29d. Date signed (Month, Day, Year) address of perso who completed cause of death (Item 23a) (Type, Print) Merry Medical Center 301 ST. Paul ST. Belto. 21202 MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

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State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9:00 P M July 2008 Katherine Bennett /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery 9830 Capitol View Ave. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🔽 F 91 Yrs. July 8, 1917 Minnesota 468-14-5546 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 7 is marked other than "natural" or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 1 ☑ Yes 2 □ No Director Appleton Wis. Outagamie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 54915 300 W. River Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or iter 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. White 3 3℃Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pancur Mlakar Cecillia 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 Is any injury or other trau 300 W. River Rd., Appleton, WI John T. Vennett / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory: 7/19/2008 22. Name and Address of Facility
Rapp Funeral & Cremation Services Signature of Funeral Serve Lie page

Multiple Multiple Manuarum 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Non Sma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-tran The law requires that the death certificate be execu Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown s been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b rector, page 2 sh autopsy performe 2 No 1 ☐ Yes 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Be Daughter's Hospital: Other: 4 Nursing Home 5 Residence 6 ther (Specify) Home 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: . completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Hame and address of person who completed cause of death (Item 23a) (Type, Print) 2730 UNIVERSITY BUD IF GO, WHEATON, MID MD ~~ OA 119 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Hegistrar

DHMH 17 Rev 1/2001

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of Fillit III Didok ilidelible lilk. Elisale Ali oopies Ale Leg State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) Month Day Vear **Physician** 2008 Ε. BEATTY JULY 20 16:06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death Examiner PRINCE GEORGE'S WASHINGTON HOSPITAL CENTER Ft. WASHINGTON Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days M 2□F 1/14/1967 Tampa, Florida Director 577-82-4881 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10b. County 10a State No Yes 2 No Directo Maryland Prince George's Fort Washington 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number rai", or items 23a or Examiner must be r 1719 Dania Drive 20744 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2√2 No Baltimore, Maryland 21215-0036 Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Black "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education
(Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Inter- Con Security Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Menta fitem 27 is marked r other traumatic ev Addie Lula Berry ည George Leedel Beatty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1719 Dania Drive Fort Washington, Maryland 20744 Tara L. Beatty / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 nent of H ant: If ite 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of important: If any injury or once. 7/23/2008 | Alexandria, VA 5 ☐ Other (Specify) Metropolitan Crem. 4 ☐ Donation 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) TERMINAL FU KEMIA **Physician** /Medical Due to (or as a consequence of): Examiner SEPTIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Morusoci Division or Vital Records, P.O. Box 68760. Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Wiknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 2 ER/Outpatient 3 DOA 1 Yes ဥ after death.

Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 27. Manner of Death 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours at To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 29292000 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. SAMUEL KLEIMAN, MD. 11711 LIVINGSTON Rd., FORT WASHINGTON, MD. 20744 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

08-05531 Lynn Beckwith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 23655

		- For State egistrar		Certific	cate of	f Death					Reg. No.		10.00	-
Physicia		. Decedent's Name (First, Midd	le,Last)							Date of Dea Month	Day	Year	3. Time of Death	
edical Examin		Lynn Beckwith								July 19, 2	2008		1134 hrs	_
φ.74.		a. Facility Name (if not institution	on, give street and nu	umber)		4b. City, Tov		cation of [	Death		1	County of De Baltimore C		
		302 East Joppa Road						If Under 2	24Hrc 1	9 Date of B	irth/MM/	DD/YYYYY 9.	Birthplace (State or Foreig	an
Funeral Director		Social Security Number	6. Sex	7. Age (In yrs. last bi	rthday) Yrs	If Under Months	Days	Hours	Min.				Country)	
		217-60-2039	I WI ZAI		Yrs. 6-11-1955									
	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Loca	tion							10d. Inside City Limits	3
and show any nce.						City							1 X Yes 2 No	5
aryland 8a-f sho	흱	Md . 10e. Street and Number			LINOTE	10f. Zip C	ode				10g. Citi	zen of What C	Country?	$\neg$
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Director	3515 Reist	erstown					2121	5	1		USA		
death with the Moor items 23a or 2	딞	11. Marital Status		cedent Ever in U.S.	13. W	as Decedent	of Hispa	anic Origin	n? (Spec	cify Yes or N	io-		merican Indian, Black,	$\neg$
ath w	Funeral		Married Armed F		lf '	Yes, specify	Cuban, I	Mexican, F	Puerto Ri	ican, etc.)		White, et	c.	
ter de		3 Widowed 4 X Di	Specify:	White										
hours after 'natural'', Examiner		15. Decedent's Education (Spe	ecify only highest gra	ade completed) 16a	. Decede	nt's Usual O	ccupatio	n (Give ki	nd of wo	rk done	16b.	Kind of Busine	ess/Industry	
72 hor	뺡	Elementary/Secondary (0-12		ŀ										
21215-0036 uld be filed within 73 Mental Hygiene. marked other than c event, the Medical	Completed	11th	isabled	$\dashv$										
ed will have other when we have	3	17. Father's Name (First, Middle					18			First, Middle But1		i Surname)		
21215 uld be filed Mental Hy marked of	Be	Richard Jab		7. 0. 1.)										
21 Duld H Mer mar	P	19a. Informant's Name/Relation	State, Zip Code)											
MD id 2 sho alth and m 27 is aumati		Doris J. Butt Mother 4504 Forge Rd. Perry Hall, Md. 21												-
ore, MD 21215-00.  st and 2 should be filed with of Health and Mental Hygiene If iten 27 is marked other the traumatic event, the Men	- 1	20a. Method of Disposition				osition (Name other place)	e of cem	etery,		Date	20c.	Location - Ci	ty or Town, State	
Baltimore, MD 21215-0036 bemit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		1 XBurial 2 Crematic			land	Momor	i a 1		7-23	-2008		Parkvi:	11e	
Baltimo permit. Pages Department o Important: I	1	4 Denation 5 Other Specify: Moreland Memorial 21. Sign ture of Foreral Service Livington Service Livington Service Livington Schimunek Funeral											Home	
Dep Den Injury	3 20	9705 Rolair Pd Nottingham Md 2											1236	
Physician		23a. Part I. Enter the disease, of failure. List only one caus	or complications that	caused the death. Do	not enter	the mode of	f dying, s	such as ca	rdiac or	respiratory a	arrest, sh	nock, or heart		
A /Medical		Immediate Cause (Final diseas	Manitiple Ir	njuries									Death	_
aminer	- 1	or condition resulting in death)		a consequence of):										
		Sequentially list conditions,	b	a consequence of):				_						
	in a	if any, leading to immediate cause. Enter Underlying Caus	e	a consequence or,										_
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687 ertific iding	ia /	23b. Was decedent pregnant in past 12 months?		e birth gnant at time of death		Fetal death Other (Spec		Ectobic	pregnar	icy				- 1
Box 687 e death certifite the attending	Physicia	1 Yes 2 V No 9	latina sum S	known	3	Other (Spec					1			
J. B. the de by the ached f	P.	Part II. Other significant cond	ditions contributing	to death but not resu	lting in the	e underlying	cause g	iven in Pa	irt I.				ute to the cause of death?	
, P.O. ires that the signed by	by									1	Yes 2	1500	Probably 4 Unknow	-
ords, w requires been so	Completed	/, <del></del>								24a. W	as an utopsy		ere autopsy findings availat or to completion of cause of	
COF law r has b	du									pe	erformed es 2		ath? ✓ Yes 2 No	
tal Recting The certificate ector, page	Co						26 Place	of Death	(Check o					-
Vital Rec ysician: The l his certificate l	Be	25. Was case referred to medi examiner?	Hospital:	Inpatient 2 EF	R/Outpatie			Other <sub>4</sub>		g Home 5	Resi	dence 6 🗸	Other: Scene	
FVI Physic rthis al dir	2	1 Yes 2 No	'-	,pecter	Bb. Time		J.,	ry at Work	2	28d, Descri	ibe how i	injury occurred	<u> </u>	_
n of \ ding Phy.	ü.	27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending 28b. Time of Injury 1129 hrs 28b. Time of Injury 1129 hrs 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occur Subject jumped from but											ding	
SiOI Mten death cetor;	cati		ventination	lace of Injury - At home	e farm. si	treet, factory	, office b	uilding, et	tc.				or Rural Route Number, C	City
Division of Vital Records, tal or Attending Physician: The law require rs after death.  al Director: After this certificate has been silled in by the funeral director, page 2 should be led in by the funeral director, page 2 should be	Certification:	de de de	ould not be	fy) Multi-Family						or Tow 302 East د	n, State) Joppa R	) load, Towso	n, MD	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		4 Homicide	Dharisiana Taithail	and of my knowledge	death oc	curred at the	e time, da	ate and pla	ace, and	due to the	cause(s)	and manner a	as stated.	
the H iin 24 the Fr	Medical	(Check only one) 2 Medical E	xaminer: On the bas	is of examination and	or investi	igation, in my	opinion	, death oc	ccurred a	it the time, d	late and	place, and du	e to the cause(s)	
To T To 1	Med	29b. Signature and title of cert	and manne	er stated.		290	c. Licens	e number			29	d. Date signe	d (Month, Day, Year)	
		1/10/1	1 D	$\cap$			O.C.	M.E.			J	uly 20, 200	8	
		Utte	was subs some lated a	ause of death (Item 2	3a)									_
n		30. Name and address of pers Laron Locke MD.	on who completed of Assistant Medi	cal Examiner	, 111 Pe	nn Street	, Baltir	more, N	1D 212	01				
				Registrar's Signatur	100	rack 8								
Penis	tate		3 2008   %	MARKEN JU	Je je	1								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jul 21, 2008 Year **Physician** 1:20 P<sub>M</sub> Lois C. Baker /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Howard Ellicott City 2406 Mt. Hebron Drive If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 □ M 2 🗙 F 220-38-7182 91 Director IL Jun 16, 1917 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Howard **Ellicott City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2406 Mt. Hebron Dr. 21042 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No. If Yes, Give (Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. <u>م</u> Specify: 3 □ XVidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( George Washington Collier Melissa Caroline McCarty 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory Peddicord Grandson 2625 North Rogers Ave. Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Good Shepherd Cemetery Jul 24, 2008 Ellicott City, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULMONARY EDEMA **Physician** disease or condition resulting in death) MEEK /Medical Due to (or as a consequence of): Examiner VALVULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 ← attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death the 9 I Inknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ REGURGITATION ATHEROSCLEROSIS MITRAL 2 X No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No death? 1 ☐ Yes 1∐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) . Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Hospital of within 24 hours at To the Funeral E Two Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Definition Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title 038296 JULY 22,

State Registrar

30. Name and add

OMD

ss of person who completed cause of death (Item 23a) (Type, Print)

-61BBONS

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, Month **Physician** Z008 /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Villa Nursing+REhab CTR. BALTIMORE CATONSVILLE 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Hours Min. **Funeral** 1 ☐ M 2 🗹 F 3-16-23 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hyglene. ant. If item 272 is marked other than "natural", or items 23a or 28a-f shou ury or other traumatic event, it. Medical Exprehence and be retified at ury or other traumatic event, it. Medical Exprehence and be retified at 1 ☐ Yes 2 🖪 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Neyer Married 2 ☐ Married 1 ☐ Yes 2 No Specify SHITE Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DEPT. STORE ANIC R157 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) . ARBUTUS, MD. 21227 DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 Removal from State HANDVER, MD. -7-08 REMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility DaughERTY Family Further Home 2601 MOUNTAIN RO. PASADENA, M.D. Z1122 Approximate Interval Between Onset and Death Part 1. Enter the disease shock, or heart failure. List only o not enter the mode of dying, such as cardiac or respiratory arrest omplications that caused the daily one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed Exami attending physician and for use as the burlal-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 5 ☐ Other (specify) P.0. cate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has performed death? 2 No 1 □Yes 2 1 ☐ Yes Division of Vital 26. Place of Death (Check only one) funeral director, 25. Was case referred to nedical Be examiner Other: 4 vursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 1€ this Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death After t Injury 1 Natural
2 Accident 5 Pending investigation To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ernende 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N ROLLING RD SHE 205 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

AMAWA 08-04805
UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Certificate of Death Reg. No 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death Medical Examiner Month 0638 hrs Amanda Bishop June 22, 2008 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1300 block Nanticoke Street **Baltimore** 5. Social Security Numberunk 6. Sex **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months Days Foreign Maryland Director Hours Min 1985 2X F 22 Dec 19, M Usual Residence of Decedent 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 No MT Baltimore must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 337 S. Payson Street 21223 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married Armed Forces White, etc. 2 2 X No Yes hours after Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White the Medical Examiner Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hou
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nat
injury or other transmatic event, the Medical Exa during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 disabled none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Jr. Bishop Shirley Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby Gomez/friend 337 S. Payson Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in state 21. Signature of Forecas Service Ligers Wadle, Director 25 Nare and Address of Explit Board 655 W. Baltimore Street Baltimore, MD 21201 rt I. Enter the disease. **Physician** complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval ure. List only one cause on each line. Between Onset and /Medical Death a. Asphyxia by strangulation Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed d. Physician/Medical 28e, perME, g881 //23/08 TT icate has been signed by the attending physician a page 2 should be detached for use as the burial -UNPENDED AMENDED P.O. Box 68760, IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed death? ✓ Yes 2 1 V Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be Other Hospital: 1 Inpatient this ER/Outpatient 3 DOA Residence 6 V Other: Scene Nursing Home 5 1 V Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Natural FOUND: Subject assaulted Pending Yes 2 V No 0630 hrs Jun 22, 2008 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. FNd: Grassy area near sidewal 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 1300 block Nanticoke street, baltimore, MD determined 4 V Homicide (Specify) Other (specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day Year) O.C.M.E. June 22, 2008 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/200 **OCME 2006** 

State

Registrar

JUL

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 19a per th 9801 7-28-08 vt. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July **Physician** 2008 4:25 AM Patricia Ann Blair /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign
Country) 8. Date of Birth (Month, Day, Year) July 14, 1937 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🕱 F Months 71 Maryland 216-32-2807 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County t∩a State 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the "e-dical Experience must be notified at 1 □Yes 2 No Director Lutherville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 31 E. Seminary Ave. 21093 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo "natural", or Specify Specify: þ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, Item Me Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Hulsman Gertrude Stritch ပ 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lutherville, MD 21093 31 E. Seminary Ave. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem GardJuly 21,2008 4 Donation 5 Other (Specify) Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Rd. Baltimore, MD 21212 Approximate Interval Between Onset and Death 23a art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DAYS **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ENTEROVA INAL FISTULA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed LUMPHOMA physician and s the burial-tran Due to (or as a consequence of) O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the detached 9 Unknown signed by to be a signed by the detach ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has autopsy performed? 1 Yes 2 No this certificate To the Hospital or Attending Physician: " within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) After thi funeral ( 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No neral Director: A 2 Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title D64395 JULY 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 6565 N CHAPLES ST, SUITE 209 BALTIMORE, MD 21204 DANIEUE DOBERMAN, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** ALICE PAULINE FORD BOSLEY July 21 5:43P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPICE OF BALTO AT GILCHRIST CENTER Towson Baltimore County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth May 6, 1938 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Hours Min. Months Days 1 □ M 2 🔯 F 70 219-34-1514 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Baltimore County Cockevsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 3 10404 Greenside Drive 21030 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 X Married 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 X No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Residence other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Edward Ford, Jr. Mary Pauline Kenney ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Guy F. Bosley 10404 Greenside Drive, Cockeysville, Maryland 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Poplar Grove Cemetery 7/24/2008 | Phoenix, Maryland permit. 21. Signature of Function Serving Line see 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC. aum Martin U. Lawson 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Levicemia disease or condition resulting in death) Rais /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. The Clause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and attending physician are for use as the burial-t Due to (or as a consequence of): P.O. Box 68760, death certificate be Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 7 No 1 ☐ Yes 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy 1 □Yes 2 No Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA pice funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation within 24 hours after death.

To the Funeral Director: At completely filled in by the fun death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) July 22, 2008

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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32. Registrar's Signature

N. Charles St. Boelto and 2,20%

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Certificate of Death

3altimore, Maryland 21215-0036

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. this

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** lemnis /Medical City, Town, or Location of Death 4a. Facility Name (If not institution, give street and numb Examiner 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F MAR. 26, 1934 MD Director 213 30 1525 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
Instit of Health and Mental Hyglene.
Instit if iten 27 is marked other than "natural", or items 23a or 28a-f show mir; if iten 27 is marked other than "natural", or items 25a or 28a-f show iny or other traumatic event, the Medical Examiner must be notified at my or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21209 USA 4800 YELLOWWOOD RD. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
X☐Yes 2 ☐ No NAVY
If Yes, Give
Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SeagramsDistillery LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PAULINE MELLO GEORGE B. BRITTON ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) COREY P. BRITTON (son) 13918 Carlene Dr. UpperMarlboro, MD.20772 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from Stat BALTIMORE CEMETERY July 26,2008 BALTO, MD. gnature of Funeral Service Licensee CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 23a. Part1. Enter the disease, or complications that caused law do shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physician and s the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 pronths? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? ntributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ known Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → 100 24a. Was an autopsy perfori Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion death occurred. 24 hours Funeral 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of certifier State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 per dr/dvr 8881 07/33/98dhb 20a/fh 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 04:00 AM 06 ) aver nna /Medical County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day If Under 1 Year 9. Birthplace **Funeral** Months Min. Hours 1 □ M 2 X F Days Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the "nation Experience must be notified at 1 ☐ Yes 2 No Completed by Funeral Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code illed within 72 hours after death with 21286 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify. nite 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DQ NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other tranonce. OLL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Pages 1 1 ☐ Buria! 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Skarda Funeral Home, **Thomas** 8 á . Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac Immediate Cause (Final **Physician** TEM disease or condition resulting in death) chronic /Medical Due to (or as a consequence of) Examiner ertensio Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transi Exami Due to (or as a consequence of) P.O. Box 68760 requires that the death certificate be Physician/Medical signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 2 🗆 No 2 □No 1 □Yes 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 Inpatient ٩ After this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 1 TYes 2 No death. 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after d 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OL TOT 32 Registrar's Signature 31. Date filed (Month, Day, Year)

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State

Registrar

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		,	For State Registrar	Please			nd / Depa		a. <b>Ensure /</b> Health and <i>Death</i>	Mental Hyg	_	_	8663
	Physici	an	1. Decedent's Name (Fire Edna Cust		st)				-	2. Date of Dea Month	Day	3. Time of 3. 7	
	/Medic Examir		4a. Facility Name (If not in Doctor's	institution, give		ber)		4b. City, Town, C	or Location of Deat		4c. County of		
	Funeral Director		5. Social Security Number 579–20–4292	r 6.S		7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days			h y, Year)	9. Birthplace (State Country) South Card	
	f show	or		. County	Georges		ty, Town or Lo	ocation				10d. Inside (	City Limits s 2 ☐ No
	h the A	Director	10e. Street and Number					10f. Zip Code			10g. Citizen of WI	nat Country?	
	23a c	ral	12323 White	Hall I	Orive			2071			USA		
980	within 72 hours after death with the Maryland sne. than "natural", or Items 23a or 28a-f show as Mydical Evartinet rust be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2  3XXWidowed 4 ☐ I	_	12. Was Deced Armed Ford 1 ☐ Yes 2 If Yes, Give Year or Da	es? XXXIIo	- 1	Was Decedent of I If Yes, specify Cub 1 □ Yes 2XXNo	Hispanic Origin? (Sean, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Black	- American Indian, , White, etc. Black	
21215-0036	n 72 ho "natur	Completed	(Specify or	Decedent's Ed	de completed)		1 (Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wo	rking	16b. Kind of Bus	iness/Industry	
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Baltimore, Maryland	2 should be filed vand Mental Hygie is marked other is aumatic event, the	To Be C	17. Father's Name (First, Richard H						1	me (First, Middle, eth McRae		)	
<b>lar</b>	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic er once.		19a. Informant's Name/F		Type. Print)				and Number or R			State, Zip Code)	
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	Physician /Medical Examiner		23a. Part 1. Enter the dis shock, or heart failt Immediate Cause (Final disease or condition resulting in death)  Seguentially list condition	ure. List only	one cause on ea	used the deat ch line. r as a conse	Irryt	mer the mode of dy	ng, such as cardia		rest,	Approxima Interval Be Onset and	etween
Box 68760,	eath certificate be executed attending physician and for use as the burlat-transit	dical Examiner	Sequentially list condition if any, leading to immedia cause. Entler Underlying Cause (Disease or injury that initiated events resulting in death) Last		cDue to (d	r as a conseq	uence of):						
o.	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after cleath.  Of the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medica	IF FEMALE: 23b. Was decedent preg in the past 12 montt 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	nant		rth 2 ☐ Feta ant at time of	I death 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	су		23d. Date Mon	of delivery th Day	Year
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o	Phys er this eral dir	.T	1 ☐ Yes 2 ☑ No 27. Manner of Death		28a. Date o	Injury	ER/Outpatier 28b. Time of	IL 3 LL DOA	4 LI Nursing i	Home 5 ☐ Resid	lence 6 ☐Othe low injury occurre		
Division of Vital Records,	To the Hospital or Attending Physician: The lawithing the Unions after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To	2 Accident	Pending investigation Could not be determined	28e. Place o	, <i>Day</i> , Year) f Injury - At h g, etc. <i>(Speci</i>	Injury ome, farm, str fy)		K? ]Yes 2 □ No	28f. Location (S City or Tow		r or Rural Route Nu	mber,
	To the Hospital within 24 hours a .To the Funeral I completely filled	Medical C				sis of examina			ime, date and plac opinion, death occ			nner as stated. nd due to the cause	(s)
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	Sta		30. Name and address of Superior Superi	Lych y, Year)	Roal 32. De	gistrar's Signa	enhan ature	Print) Md	20706	S. Dr.	ALFIE ,	7-08 Mingo	•
DI.	Registr	ar	JUL	0 9 2	008	evas s	IS A	MANU					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 2008 6:34a M DELORES E. CRAWFORD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE **GEORGES** HOSPITAL LANHAM COMMUNITY DOCTORS Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 □ M 2 🗓 F Months Hours Min. 2/7/1932 Director 76 Washington, DC 577-48-7351 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 X Yes 2 No Director Maryland | Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20785 8125 Landover Road Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 21 No Specify: Black Specify. Baltimore, Maryland 21215-003 3 Widowed 4 □ Divorced Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Child Care Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٥ William Dorsey Rosie E. Hawkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3609 Martin Luther King Jr. Ave. Wash. D.C. 20032 permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once. Demetrious Kinney / Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/29/2008 Landover, Maryland Harmony Memorial 21. Signatur of Funeral Service Licende. 22. Name and Address of Facility Pope Funeral Homes, P.A. darry d. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) multi **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit aller Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached t 1 ☐Yes 2 ☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> hiratous Coronary certery cliseas factive 1 Yes 2 No 3 Probably 4 Unknown Be Completed son in onler dependent 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed acteure type leuter or

25. Was case referred to medical examiner? asthma 1 ☐Yes 2 No 1 Yes 2 XNO funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

HospItal or AttendIng PhysIcian: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 🏵 n 24 hours after death.

Be Funeral Director: After the function of the functi within 2 To the I

filled in by

Medical

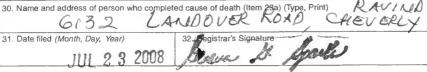
31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

6132



and manner stated

29c. License number
Day720

RAVINDER

NO

29d. Date signed (Month, Day, Year)

7/20/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Vera H. Curlett JUL /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ALTIMORE AGNES | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 29,1914 Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 M 2 → F 215-01-3529 93 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 1 ☐ Yes 2 X No пs 23a or 28a-f sh пust be notified Directo Catonsville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 719 Maiden Choice Lane ST512 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. 1 Never Married 2 Married White 0 1 ☐ Yes 2 No 21215-0036 Specify: þ 3 Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) item 27 is marked other than "natu other traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Office Supply 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Joseph Hellmann Edythe Ray Cross P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: if item 27 is any Injury or other tra once. 2541 Ashbrook Drive; Ellicott City, MD 21042 Son Lewis R. Curlett, III 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/23/2008 Woodlawn Cemetery Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service License Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Anoxic encephalopathy /Medical Due to (or as a consequence of) **Examiner** SCVD Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hours the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

iled (Month, Day,

31. Date filed (/

ddress of person who completed cause of death (Item 23a) (Type, Print)

D 30989

711 Maiden Choice Ln Catonsville MD 21228

08-05339 Hur

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician Medical Examine Plants and Control Plants (Page 1) and Control Plants (Page 2) and Control Plants (Page	Hurley Cross, Jr.		State of Maryland / Department of Health and Mental Hyg  1-For State Certificate of Death  Registrar		a. No. 201	
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Second Source   Superior   Supe	/		4a. Facility Name (if not <sup>1</sup> institution, give street and number)  4b. City, Town, or Location of Death	July 12, 20		
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The state of the s			219-86-0757 1 Mm 2 F 32 Yrs. Months Days Hours Min.	Apr. 17	Fore	ion
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Physicial Medical Remainer   238 Part Lenter the disease, or complications that caused the earth. Do not enter the mode of dying, such as cardiac or respifatory arrest, shock, of heart Between Onset and Death   248 Part Lenter the disease or activities   249 Part Lenter the mode of dying, such as cardiac or respifatory arrest, shock, of heart Between Onset and Between Onset and Death   249 Part Lenter the mode of dying, such as cardiac or respifatory arrest, shock, of heart Between Onset and Death   249 Part Lenter the mode of the disease or activities   249 Part Lenter the mode of the disease or activities   249 Part Lenter the mode of the disease or activities   249 Part Lenter the mode of the disease or activities   249 Part Lenter the mode of the disease or activities   249 Part Lenter the mode of the disease or activities   249 Part Lenter the mode of the disease or activities   249 Part Lenter the mode of the disease or activities   249 Part Lenter the disease or activities   249 Part Lenter the mode of the disease or activities   249 Part Lenter the mode of the disease of the disease or activities   249 Part Lenter the mode of the disease or	altin mit. Pa partmen portan ury or	7	4 Donation 5 Other Specify: 10011 2:070 Cemetro 3 Outgraph 2:070 Cemetr	e P.A.	J41003000	one ria gano
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Sequentially list conditions, sequence of):    Due to (or as a consequence of):			failure. List only one cause on each line.	aspiratory arre	st, shock, of flear	Between Onset and
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Part II. Other significant conditions   Part II.   Part III.   Part II.   Part III.   Part II.   Part III.   Part II.   Part III.   Part II.   Part III.   Part II	5876 rtificate ling phy		23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnance	;y		*
Part II. Other significant conditions   Part II.   Part III.   Part II.   Part III.   Part II.   Part III.   Part II.   Part III.   Part II.   Part III.   Part II	leath ce attend for use	SICE	4 Pregnant at time of death 5 Other (Specify)			
290. Signature and title of certifier  FOVL TAKY RIPPLE, ND  O.C.M.E.  July 12, 2008  30. Name and address of person who completed cause of death (Item 23a)	O. E is the d by the etached					
290. Signature and title of certifier  FOVL TAKY RIPPLE, ND  O.C.M.E.  July 12, 2008  30. Name and address of person who completed cause of death (Item 23a)	S, P. P. Initial straight and signer of Id be de	ed b				
290. Signature and title of certifier  FOVL TAKY RIPPLE, ND  O.C.M.E.  July 12, 2008  30. Name and address of person who completed cause of death (Item 23a)	Cord	nple		autops perfor	sy prior to med? death?	completion of cause of
290. Signature and title of certifier  FOVL TAKY RIPPLE, ND  O.C.M.E.  July 12, 2008  30. Name and address of person who completed cause of death (Item 23a)	Re n: The rtificate or, page		25. Was case referred to medical 26. Place of Death (Check onl		2 No 1 🗸	Yes 2 No
290. Signature and title of certifier  FOVL TAKY RIPPLE, ND  O.C.M.E.  July 12, 2008  30. Name and address of person who completed cause of death (Item 23a)	Vita bysicia this certain direct	m	examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing H	Home 5	Residence 6 Oth	er:
290. Signature and title of certifier  FOVL TAKY RIPPLE, ND  O.C.M.E.  July 12, 2008  30. Name and address of person who completed cause of death (Item 23a)	n of ding P h. : After e funera		27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?  28c. Injury at Work?  28d. No  28d. Injury at Work?  28d. Injury at Work?  28d. Injury at Work?			collision
290. Signature and title of certifier  FOVL TAKY RIPPLE, ND  O.C.M.E.  July 12, 2008  30. Name and address of person who completed cause of death (Item 23a)	r Atter r Atter ter deat irrector in by the	licat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28			
290. Signature and title of certifier  FOVL TAKY RIPPLE, ND  O.C.M.E.  July 12, 2008  30. Name and address of person who completed cause of death (Item 23a)	Djy Spital o tours af meral D	를    -	4 Homicide determined (Specify) Local Street			
290. Signature and title of certifier  FOVL TAKY RIPPLE, ND  O.C.M.E.  July 12, 2008  30. Name and address of person who completed cause of death (Item 23a)	the Hornin 24 Fundherely	Ica	Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and do	ue to the cause he time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)
O.C.M.E. July 12, 2008  30. Name and address of person who completed cause of death (Item 23a)	To with	ĕ-	29b. Signature and title of certifier 29c. License number		29d. Date signed (N	fonth, Day, Year)
					July 12, 2008	
🦅     Mary G. Kippie Md.   Deputy Chief Medical Examiner   TTT Penn Street, Baltimore, MD 21201	2		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Mary G. Ripple MD. Deputy Chief Medical Examiner</li> <li>111 Penn Street, Baltimore, MD</li> </ol>	21201		
State 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature			31. Date filed (Month, Day, Year) 32. Gegistrar's Signature			
Registrar		_	The second secon			

DHMH 17 Rev 1/2001 OCME 2006

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 1:09 AM James Carl Coleman 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince George's Laurel Laurel Regional Hospital 9. Birthplace (State or Foreign | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 21, 1929 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number 1**X** M 2□ F Alabama 78 323-24-1495 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State 1 ☐ Yes 2 No Columbia Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21045 5718 Old Buggy Court 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ∏ Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Howard University 5+ Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Dixon Jacob Coleman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5718 Old Buggy Court Columbia, MD 21045 (Wife) Alice Faye Coleman 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-19-2008 Catonsville, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart mure. List only one cause on each line. Approximate Interval Between Onset and Death 6 Days Immediate Cause (Final Clostridium Difficile Colitir disease or condition resulting in death) Due to (or as a consequence of) 2 Weeks Multi-Drug Resistant Acinetobacter Bacteremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 2. Weeks Multi-Drug Resistant Pneumonia Due to (or as a consequence of): 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3.☐Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed 3E No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Injury 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident

attending physician and for use as the burial-transit P.O. Box 68760. certificate be detached Division or Vital Records, page 2 should peen has

**Physician** 

/Medical

Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

2

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event than "natural".

Baltimore, Maryland 21215-0036

Examiner Physician/Medical ð Completed certificate funeral director, Be this Certification: After .al or Atten.
.us after death.
.neral Director; A'

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 No

5 Pending investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3∏ Suicide 4 Homicide

t☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

JUL

29c. License number D66515

29d. Date signed (Month, Day, Year)

July 15, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10724 Little Patuxent Pkwy Suite 200 Columbia, MD 21044 Nishi Rawat, M.D. 31. Date filed (Month, Day, Year)

State Registrar

Medical

within 24 hours a

341

				partment of Health and Mertificate of Death	lental Hygien	- ZUUB /3669
		-	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medic		LeCount Samuel Dickerson			2008 Year 4:50 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
			Pineview Nursing Home	Clinton		Prince George's
Ε.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea.	
an is	Director		577-22-5645 87 Yrs. Usual Residence of Decedent		March 3,	1921 Washington, DC
vland	at		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
N	a-f sh ified	ctor	Maryland Prince George's Clinton			1★ Yes 2 No
ith the	or 28	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
ath w	s 23a nust b		9106 Pineview Lane	20735		United States  14. Race - American Indian,
er de	items	Funeral	11. Marital Status 1. Was Decedent Ever in U.S. Armed Forces? 1. Never Married 2 Married 112 Yes 2 No	<ul> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> </ul>	Rican, etc.)	Black, White, etc.
136 Is aft	raml xaml	by F	3 ₩ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Black
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<b>7</b>	ygien t, the	ပ္ပ		iver's Assistant	(Cina Middle Maid	Private
ind he	d oth	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide	en Surname)
	d Mer narke	ဥ	Samuel Dickerson  19a. Informant's Name/Relationship (Type. Print)  19b. Ma	iling Address (Street and Number or Rur	Jackson	or Town State Zin Code)
Maryland d 2 should be file	th and		, ,	Eastern Ave, NE #4		
<b>6</b>	to Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a Mathed of Disposition 20b. Place of Dis	•		Location - City or Town, State
				Nat'l Cemt. July	11, 2008	Triangle, VA
Baltimore,	Department of Important; If any Injury or once.			22. Name and Address of Facility St		
n i	e a m		Manager Daniel	4001 Benning Road	, NE Washi	ngton, DC 20019
			23a. Part1. Ener the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or conditiona Cancer of Prosta	ite with Metastasis		Onset and Death
	/Medical xaminer		resulting in death)  Due to (or as a consequence of):			
	Aariillei	-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
ted	nsit	nine	Cause (Disease or injury			
), execu	n and ial-tra	Examiner	that initiated events resulting in death) Last c		***	
ecords, P.O. Box 68 760, law requires that the death certificate be executed	hysician and the burial-transit	ical	d			
	ng ph as th	Nedi	IF CEMALE.		500	
Both cert	attending p	Physician/Med		B Ectopic pregnancy		23d. Date of delivery  Month Day Year
j E	the al	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (specify)		,
J. F	ned by the a		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
GS,	signe d be	d by	Anemia, Gastrointestinal Bleeding		1 ☐ Yes	2万 No 3☐ Probably 4☐Unknown
<b>Mecords</b> , he law requires t	been sig	lete			24a. Was an	24b. Were autopsy findings available
	certificate has l	Completed			autopsy performed? 1 Yes 2 1	
	certificat rector, pa	0	25. Was case referred to medical	26. Place of Deat	h (Check only one)	40 TETES 2E110
	07	To B	examiner? 1   Yes   2X No	ent 3 DOA Other: 4 Nursing Ho	me 5 Residence	6 □Other (Specify)
	h. After thi funeral c		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	Work?	28d. Describe how in	jury occurred
VISION	ier death. Irector: A I by the fu	cati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm,	M 1 Yes 2 No	20f Location (Street	and Number or Rural Route Number,
<u> </u>	i i ii ii	Certification:	4 Homicide determined building, etc. (Specify)	street, factory, office	City or Town, Sta	
Hospital	urs erat		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place,	and due to the cause	(s) and manner as stated.
the Ho	(U as (D)	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, date a	and place, and due to the cause(s)
10 1	within To the compl	Me	29b. Signature and itle of certifier	29c. License number	29d. [	Date signed (Month, Day, Year)
	(		· Armid	D51520	Ju Ju	ıly 7, 2008
R	(5)		30. Name and address of person who completed cause of death (Item 23a) (Typ		au, H.D.	
1		to	1328 Southern Avenue, SE #310 Wash: 31. Date filed (Month, Day, Year) 32. Registrar's Signature			
×.	Sta Registr		31. Date filed (Month, Day, Year)  JUL 0 9 2008  32. Registrar's Signature			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 07:35PM Month 07 17 Day **Physician** Anne Davis 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Gilchrist Hospice Center Baltimore Baltimore Co. If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 05/25/1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Months 104-46-4172 86 Romania Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, its Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Baltimore Perry Hall 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9108 Pannorama Dr. 21128 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 25 Married 1 ☐Yes 2 If Yes, Give 1 ☐Yes 2 No Specify: White ð 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7: th and Mental Hygiene. 7 is marked other than "n Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Vasilescu Stephanie Sandu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Howard Davis/Husband 9108 Pannorama Dr. Perry Hall, MD 21128 Department of Health Important: If item 27 any injury or other troops. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/21/08 Chesapeake Crem. Beltsville,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses CAFA - 8717 Green Pastures uce Dr. Balto.,MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CON nemic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of burial-tran Due to (or as a consequence of) physician s the burial Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of eath 28d. Describe how injury occurred Medical Certification: To the Hospital or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name(and address of person who completed cause of death (Item 23a) (Type, Print) eraples 82. Registrar's Signature State Registrar

iease	ype or Print in bi	ack muenble mk.	Elisure Ali Co	phies wie i
	State of Maryland	Department of He	ealth and Menta	al Hvaiene

n black indelible ink. Elisure All Copies Are Legible.		
and / Department of Health and Mental Hygiene	2008	23671
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Jason Robert Dec		- For State	St	ate o	f Maryland		artment <i>rtificate</i>			d Ment	al Hygi		an No	20	08	2367
Physicia	n/	Registrar 1. Decedent's Name										Date of Deat Month	eg. No. th Day	Year		of Death
Medical Examin		Jason 4a. Facility Name (i				1		I₄h C	ity, Town, or	Location of	J	uly 16, 20	008	County of Dea		0 hrs
}		222 S. Clint		ii, give s	treet and number	,			altimore	Location				Baltim		
Funeral Director		5. Social Security N 218-84-		6. Sex	7. A	ge (In yrs. 32	last birthday	_	onths Day	_		. Date of Bir 0/06,	,	7.5 Fore		
any		Usual Residence of 10a. State	Decedent 10b. County			10c. City	, Town or Lo	ocation							10d. In	side City Limits
Ce an		MD	Harf	ord		1	ingdo								1 🗌	Yes 2 No
2 darylan 128a-f s	an I	10e. Street and Nu	mber			1	0	10f	Zip Code				0g. Citi			
h the N		2904 Pr	eston						21009					ted St		
ath wil	Funeral	<ol> <li>Marital Status</li> <li>Never Marrie</li> </ol>	ed 2 N		12. Was Deceder Armed Forces	?	J.S. 13.		cedent of His pecify Cubar					White, etc.		an, black,
after de	by Fu	3 Widowed	4 Di	vorced	1 Yes 2 Yes, Give Year or Dates:	No									White	
hours in atura	ed le	15. Decedent's Ed			highest grade co				sual Occupa f working life				16b. F	Kind of Busines	s/Industry	
)36 hin 72 te. than "	Completed	Elementary/Second 11	ondary (U- 12)		College (1-4 of	5+)	M	ove	r				M	oving	Comp	oany
5-0C iled wil Hygier I other																
	ш	Lewis Walter Decker  Helen Theresa Gibbs  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town,											ite, Zip Co	ode)		
MD ; id 2 shot lith and 1 m 27 is raumatic	- 5	Lewis D												MD 210		
s 1 and s 1 and of Healt If item		20a. Method of Dis		n 3	Removal from S		Place of Dis crematory of	r other p	lace)		_	ate	1	Location - City		
Baltimore, permit. Pages 1 a. Department of He Important: If ite Important: Impo		4 Donation 5	Other S	pecify:		G	nesap		e Gre			_	_	Beltsv		
Bal permit Depar Impor		21. Signature of Fu	. (	License					, Bal		\ .A	.FA- 8	871	7 Gree	n Pa	astures
Physician		23a. Part I. Enter the failure. List on	ne disease, o	r complic	ations that cause	d the deat						espiratory ar	rest, she	ock, or heart		oximate Interval veen Onset and
Medical xaminer		Immediate Cause or condition resulti	Final diseas	e a	Narcotio			into	oxicat	ion					- 1	Death
,		Sequentially list co		b	ue to (or as a con	sequence	or):									
	ie	if any, leading to in	nmediate		ue to (or as a con	sequence	of):									
172.	Examiner	(Disease or injury to events resulting in		D.	ue to (or as a con	sequence	of):									
execut m and ll - tra	edical	X UNPENDED		¬ -	AMENDED 23	a,27,	28a-f	, per	rME, g	882 8	3/7/08	3 TT				
68760, certificate be ending physicia	Med	IF FEMALE:			23c. If yes, outo	ome of pre	egnancy						23	d. Date of deliv		
6876 certificate anding phy	<u></u>	23b. Was decedent past 12 month	pregnant in s?	the	1 Live birth Pregnant	at time of o	teath 5	Fetal d	eath 3 (Specify)	Ectopic	c pregnanc	У		Month	Day	Year
Records, P.O. Box 68760 The law requires that the death certificate cate has been signed by the attending physpage 2 should be detached for use as the b	hysici	1 Yes 2	No 9 U	nknown	9 Unknown							Too Div			la the ee	on of dooth?
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by uneral director, page 2 should be detach	by P	Part II. Other sign	ificant cond	itions o	contributing to dea	ath but not	resulting in	the unde	rlying cause	given in Pa	art I.			use contribute  No 3 F		
ds, Fequires								-				24a. Was		24b. Were	autopsy f	indings available tion of cause of
Records, The law require ficate has been si, page 2 should t	Completed		<u></u>									auto perfe	ormed?		?	2 No
Vital Rec ysician: The his certificate director, page	ωl	25. Was case refe	red to medic						26.Plac	ce of Death	(Check on					
on of Vital   ending Physician: sath. or: After this certif the funeral director,	To B	examiner?	2 No	Ho		tient 2	ER/Outpa		DOA Ini	Other		Home 5		ence 6 🗸 Of	her: Scen	e
n of \inding Phy.ih.	ë	27. Manner of Dea		nding	28a. Date of Ir (Month, Day	(Year)	28b. Time	e or injury	´ l	Yes 2 X		ınk	7 11OW 111	gary occurred		
Division ra for Attendi rs after death. ra Director: A	Certification:	2 Accident 3 Suicide		estigation	200 Place of		home, farm,	street, fa	actory, office	building, e	etc. 2	8f. Location or Town,		and Number or	Rural Ro	ute Number, City
Div pital o	Serti	4 Homicide	det	ermined	(Specify)	Home					- 1-	2 S. C	lin			timore, M
Division  To the Hospital or Atte within 24 hours after der To the Funeral Directo completely filled in by it		29a. Certifier (Check only one)	Certifying Medical Ex	Physicia aminer:	n: To the best of On the basis of ex	my knowle	edge, death and/or inve	occurred stigation,	at the time, on my opinion	date and pl on, death o	lace, and di ccurred at t	ue to the cau he time, date	use(s) a e and p	ind manner as s lace, and due to	stated. o the caus	e(s)
To t To t	Medical	29b. Signature and	, _		and manner state	d				nse number				. Date signed (		
KICH		(/C)	ara	lock	eme	)			0.0	C.M.E.			Jul	ly 17, 2008		
CV CM	8	30. Name and add						one Ci	reet, Balt	imore 1	MD 2120	1				
OFY	ate	Laron Lock 31. Date filed (Mor			ant Medical E			eiii Sī	reet, Dalt	uniore, IV		•				
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State of Maryland / Department of Health and Mental Hygiene 23672 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** :36 AM YULY 2008 Elmer John Disque /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2701 Calgary Ave. Kensington Montgomery If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F 93 10/30/1914 PA Director 577-22-9110 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show lart: If Item 27 is marked other than "natural", or items 25a or 28a-f show lary or other traumatic event, Ir. "Nordical Exp. "in at 1. in Items and items and a large a 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Montgomery Kensington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20895-United States Funeral 2701 Calgary Ave. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces:

1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: WW JI 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: 3 M Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Utility Company Elementary/Secondary (0-12) College (1-4or 5+) Senior Finance Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be August Christian Disque Amelia Lutz ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Denise Disque/Daughter 2701 Calgary Ave. Kensington, MD 20895if of Hear 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Jul 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. Beltsville, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licenses M00382 Rapp Funeral & Cremation Services Dolinnen 933 Gist Ave. Silver Spring, Maryland 20910-Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ROSTATE 4 4EA12S /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 2 2 No e Hospital or Attending Physician: 124 hours after death. e Funeral Director: After this certifica letely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) 5 Certification: To 27. Manyler of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THAMB 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death I. Decedent's Name (First, Middle, Last) July 15, 2008 Year **Physician** Devine Margaret M. . . /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F New York May 12, 1935 Director 091-30-0729 73 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10c. City, Town or Location 10b. County a or 28a-f show be notified at 1 ☐ Yes 2 No Director Maryland Laurel Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 20708 USA items 23a c 13207 Claxton Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or item Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ State of Maryland Social Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna M. Brady Μ. Devine 2 James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 14925 Belle Ami Drive, Laurel, Maryland 20707 Thomas Devine- Brother 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State July 18, 2008 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 22. Name and Address of Facility Fleck Funeral Home 21. Signature of Funeral Service Licensee M0/23 7601 Sandy Spring Road, Laurel, Maryland 20707 Approximate Interval Between Onset and Death 5 Hours 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary Embolus /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician ar s the burial-t Division or Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE: If yes, outcome pf pregnancy
1 Live birth 2 Fetal dea
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA ဥ this 28c. Injury at Work? . Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier NA D66515 July 15, 2008 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10724 Little Patuxent Parkway, Ste 200, Columbia, MD 21044 Nishi Rawat, MD,

Registrar's Signature

**ORIGINAL** 

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 2 3 2008

i-05317 oger C. Delawdel	Stat	or Print in Black Indelible In	Health and Mental Hy		008 2367
Physician edical Examine		alvin Delawde	Death  City, Town, or Location of Death Baltimore	Reg. No.  2. Date of Death Month Day July 9, 2008  4c. County of	3. Time of Death 2050 hrs Death
Funeral Drector	220-76-62841	Sex 7. Age (In yrs. last birthday)  M 2 F L Q Yrs.	If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	- /	9. Birthplace (State or Foreign Country)
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hyginal Important: If item 71 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	11, Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorce 15. Decedent's Education (Specify Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Later 19a. Informant's Name/Relationship 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Special Service Till	ed   Armed Forces?   If Ye ed   I   Yes, Give Year   or Dales:   If Yes, Give Year   or Dales:	Decedent of Hispanic Origin? (Sp. s, specify Cuban, Mexican, Puerlo Yes 2 No specify: s Usual Occupation (Give kind of v st of working life. DO NOT use reting the company of the company	work done red)  (First, Middle, Maiden Surname)  Rural Route Number, City or Town Date 20c. Location - 0	American Indian, Black, etc.  White Iness/Industry  Chy State, Zip Code)  City or Town, State  City or Town, State
Physician /Medical caminer	23a. I. Enter the "sease, or confailure. List only one cause or Immediate Cause (Final disease or condition resulting in death)	mplications that caused the death. Do not enter the each line a. Ethanol & narcotic  Due to (or as a consequence of):			Between Onset and
Records, P.O. Box 68760,  The law requires that the death certificate be executed ficate has been signed by the attending physician and page 2 should be detached for use as the burial transit	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown Part II. Other significant condition	23c. If yes, outcome of pregnancy  1 Live birth 2 Fet 4 Pregnant at time of death 5 Oth	al death 3 Ectopic pregnater (Specify)	23d. Date of of Month  23e. Did tobacco use contrit  1 Yes 2 No 3  24a. Was an autopsy performed?	Day Year
ician: s certifi	25. Was case referred to medical examiner?  1 V Yes 2 No	Hospital: 1 ✓ Inpatient 2 ER/Outpatient  28a. Date of Injury (Month, Day, Year) Fnd 10:	niury 28c. Injury at Work?		Other:

Divisio
To the Hospital or Atten
within 24 hours after deat
To the Funeral Director
completely filled in by the Medical Certifica

3 Suicide 6 X Could not be determined 4 Homicide 29a. Certifier 1 (Check only one) 2 and manner stated. 29b. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) unk found on street

29c. License number

O.C.M.E.

28f. Location (Street and Number or Rural Route Number, City or Town, State) Wilhelm & Addison unk Sts. Baltimore, MD

July 12, 2008

29d. Date signed (Month, Day, Year)

Certifying Physiciap To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

who completed cause of death (Item 23a) 30. Name and add ss of person Mary G. Ripple MD.

Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) State 2008 Registrar

32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006** 

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Reg. No. 2008 Certificate of Death 2. Date of Death lert's Name (First, Middle, Last) 20A M **Physician** /Medical 4c. County of Death ve street and or Location of Death Facility Name (If not institution humber! Examiner Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 🔀 M 2 🗆 F Yrs Director 231-80-3983 MAY 8, Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location Show Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, it a Padical Examiner must be notified at 1 Yes 2 No Director BALTIMORE MD LANSDOWNE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with Funeral 2827 HOLLINS FERRY RD. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10TH CEMENT FINISHER CONSTRUCTION t 2 should be filed w h and Mental Hygie 7 Is marked other tl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LUCILLE FOSTER ပ THOM FOSTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health ar ant: If Item 27 Is 2827 HOLLINS FERRY, RD. LANSDOWNE, MD 21227 LATANYA WRIGHT/DAUGHTER permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5712 O DONNELL ST. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/25/2008 BALTIMORE, MD 21224 CARMEL 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Licensee 2007-09 EASTERN AVE., BALTIMORE, MD 21231 23a. Part 1. Enter the disease, promplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OBORHARYNGEAL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed as the burial-transi and Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy signed by the atte Year Month 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 4 🗂 Unknown 2 🗌 No 3 ☐ Probably 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy certificate I 2 **HN**0 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 □Yes 2 □No investigation 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1600 W MOUN DARSHAN. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Bookle Registrar

ORIGINAL

DHMH 17 Rev 1/2001

			Please	Type or Print in Black			•	
			For State Registrar	State of Maryland / D	epartment of F Certificate of		ygiene Reg. No. 200	8 2367
	Dhyoisi	an	1. Decedent's Name (First, Middle, Las	1)		2. Date of D Month	Day Year	3. Time of Death
1	Physician James Gaskin					July	4, 2008	
	Examir	er	4a. Facility Name (If not institution, give Peaceful Life /			or Location of Death	4c. County of De	
	Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs. last birth		If Linder 24 Hrs 8 Date of B	irth 9. Bi	rthplace (State or Foreign country)
h	rilgir introduc 1018		Usual Residence of Decedent	N 02		5/25/	1320	
	Maryland -f show ied at	by Funeral Director	10a. State 10b. County  MD Prince	George's Accoke				10d. Inside City Limits 1 X Yes 2 □ No
	or 28s		10e. Street and Number		10f. Zip Code	00507	10g. Citizen of What C	
	ath w s 23a nust f		725 Chatsworth		12 Was Decident of I	20607	US A	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show many injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 Mayes 2 □ No If Yes, Give Year or Dates: 1951	If Yes, specify Cub	Hispanic Origin? (Specify Yes or Nan, Mexican, Puerto Rican, etc.)  Specify:	Black, Wh	
5-0	72 ho natur dical	eted	15. Decedent's Ed (Specify only highest grad	ucation 16a. I	Decedent's Usual Occu (Give kind of work done	pation during most of working ed)	16b. Kind of Busines	s/Industry
21215-0036	within ene. than "	To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ndscaping	ed)	Busines	S
land 2	ould be filed within I Mental Hygiene. arked other han natic event, the Manatic event eve		17. Father's Name (First, Middle, Last) Edward Gaskin	1-4.		18. Mother's Name (First, Midd Mary Housto	le, Maiden Surname)	-
Maryland	nd 2 should lith and Men 27 is marke r traumatic		19a. Informant's Name/Relationship (7 Gladys G. Whitel			t and Number or Rural Route Num Orth Dr., Acc		Zip Code) 20607
ē,	s 1 and 2 of Health Item 27 I		20a. Method of Disposition	cometen	Disposition (Name of y, crematory or other pla	Date	20c. Location - City of	
E	Pages nent of h ant: If Ite		1 ☐ Buria! 2 🂢 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other ( <i>Specif</i> y	Hemoval from State	peake	7/10/2008		
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lioun	traff		ess of Facility Strickl Lentown Rd.,C		
I			23a. Panti. Enter the disease, or comp shock, or heart failure. List only	one cause on each line.		ing, such as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	Physician	Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. COPI				months
	/Medical Examiner		resulting in death)	Due to (or as a consequence of	of):	dideade		Years.
			Sequentially list conditions,	b. Interstitual lung didenal Years.  Due to (or as a consequence of):				
	uted d ansit		Cause (Disease or injury	c Due to (or as a consequence of):				
60,	be executed sician and burial-transit		that initiated events resulting in death) Last					
9289	ate be hysicia he bu			.d				
×	res that the death certificate lgned by the attending phys be detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	29c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су	23d. Date of o	lelivery Day Year
	requires that the sen signed by the rould be detache		Part II. Other significant conditions of	ontributing to death but not resulting in	the underlying cause g	iven in Part I. 23e. Di	d tobacco use contribute	to the cause of death?
ords	w require been sig should b		CHT, OBSTVI	ictive sleep o	iprea,	1[	JYes 21XNo 3□	Probably 4 Unknown
Records,	- 9 %		pulmenary	lation dyn	on,	24a. W	tonsy nrior t	autopsy findings available o completion of cause of
	iclan: The law certificate has ector, page 2:			lation dyn	diome, +		s 2 X No	
or Vital	Physiclan: this certificated director,	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	reations 3D DOA Of	26. Place of Death Check onlether:		nacify)
ō	g Phy er this eral d	Certification: To	27. Manner of Death	28a. Date of Injury 28b. T	ime of 28c. Inju		e how injury occurred	Jeony)
ion	Attending r death. ector: After oy the fune		1 Natural 5 Pending 2 Accident investigation			Yes 2□No		
Division	al or Attendl after death. I Director: A d in by the fu		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location City or	n (Street and Number or Town, State)	Rural Route Number,
	Hospita 14 hours Funeral tely filler	Medical C	29a. Certifier 1 ertifying Ph (Check only 2 Medical Example)	ysician: To the best of my knowledge niner: On the basis of examination and and manner stated.	, death occurred at the d/or investigation, in my	time, date and place, and due to to opinion, death occurred at the time	he cause(s) and manner ne, date and place, and o	as stated. lue to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	.,	29c. Licer	nse number	29d. Date signed (Mo	

Services MD 20748

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. Sindhua

6 POST OFFICE

29c. License number DO06164 n 23a) (Type, Print)

R. SINDHWANI

WALDORF, M. N. 29d. Date signed (Month, Day, Year) July 14th, 2008

WA SH State Registrar

31. Date filed (Month, Day, JUL 1 4 2008

RUAD 32. Registrar's Signatu

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 08:46<sup>₽м</sup> **Physician** Carolyn S. Grady 2008 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Perry Hall Baltimore 6 Viewridge Dr. Birthplace (State or Foreign Country)
 Ohio 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/05/1949 Social Security Number **Funeral** Days Hours 1 □ M 2 12 F 59 298-46-1920 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examiner in last be notified at 1 ☐ Yes 2 TNo Director Baltimore Perry Hall MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Viewridge Dr. 21128 United States Funeral Pages 1 and 2 should be filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: White Specify: ģ 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) tal Hygiene.  $\overset{\text{Elementary/Secondary (0-12)}}{12}$ College (1-4or 5+) Hospital E.R. Tech 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Esther Steel Hoyt Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 5068 Kemsley Ct. Rosedale, MD 21237 19a. Informant's Name/Relationship (Type. Print)
Jay Grady/Ex-husband Department of Health a Important: If item 27 is any injury or other traconce. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 07/23/08 Beltsville,MD 4 □ Donation 5 □ Other (Specify) Chesapeake Crem. 22. Name and Address of Facility CAFA - 8717 Green Pastures 21. Signature of Funeral Service Licenses MDDr., Balto., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** -IVE irchosis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 141 Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burish-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) I Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Division of Vital Records, δ 2 LINO 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 1 ☐ Yes 2 ☐ No 1 ☐Yes 25. Was case referred t edical examiner? 26. Place of Death (Check only o Be Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1∐ Yes 2 ....No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Matural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Phi 0

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's

State of Maryland / Department of Health and Mental Hygiene 0 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** Month - 0 Year 7:00 PM Miriam Jean Greenberg /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manor Care Ruxton Baltimore Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex 8. Date of Birth (Month, Day, **Funeral** Year 1 M 2 F 82 Yrs. 10/21/1925 DC 579-30-1816 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural" ~ ... any injury or other treumatic avera 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401-United States 817 Midship Ct. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 S Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Education College (1-4or 5+) Elementary/Secondary (0-12) Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Greenberg Marie Haber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marco Greenberg/Nephew 15 Wetherbee Ct. Phoenix, MD 21131-20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jul 18 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bethesda, Maryland \* 4 Donation 5 ☐ Other (Specify) Uniformed Services 2008 22. Name and Address of Facility
Rapp Funeral & Cremation Services 21. Signature of Funeral Service/Lidersee M00382 W Nokuman 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementiq **Physician** /Medical Due to (or as a consequence of): **Examiner** erebra l Vascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed ypertension Division of Vital Records, P.O. Box 68760% Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕰 No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 3 ☐ Probably 4 ☑ Inknown 1 ☐ Yes 2 ☐ No Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 **W**No the Hospitel or Attending Physician: rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပို 1 ☐ Yes 2 KNo 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pendina 1 Yes 2 No investigation 2 Accident Director: in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel [ 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 1+0054424 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. Timenium rd. #209 Timenium, MD 21093 32, Registrar's Signature 31. Date filed (Month, Day, Year) State 3

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. edent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 3:10PM 2008 ブレレソ /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner OF BALTIZMOR BALTIMORE SANAI HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month | Day, Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral 245-72-490 Usual Residence of Decedent 1 □ M 2 F Director 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f show 1 Yes 2 □ No TIMOre Funeral Director 10g. Citizen of What Country? 10e. Street and Number arrollton 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. s 1 and 2 should be filed within 72 hours after of thealth and Mental Hygiene. Her Tis marked other than "natural", or ite other traumatic event, in Modice to the standard of the medice of the modice. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Mother's Name (First, Middle, Maiden Be ို 19b. Mailing Address (Street and Number City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) la hanter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or 20a. Method of Disposition permit. Pages Department of Important: If It any Injury or o ŏ 1 Burial 2 Cremation 3 Removal from State lount Zion 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS DAYS Physician /Medical Due to (or as a consequence of): **Examiner** 7 DAYS INFECTION URPNARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month 5 Other (specify) eral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by PNEUMOTHORAX 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ACCIDENT. 24b. Were autopsy findings available prior to completion of cause of death? CLOSTRIDIUM DIFFECILE 24a. Was an autopsy performed 2 XNo 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 No within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0066946 BELVEDERE AVE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI HOSPITAL OF BACIIMORE MD, 21215 BALTIMORE 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

			For State	State of Maryland		ent of Health and cate of Death		giene Reg. No. 200{	3 23680	
			Registrar  1. Decedent's Name (First, Middle, Las	t)	Commodition Dealin			2. Date of Death 3. Time of D		
Physician /Medical			LUCY GOODMA	Fry			JUX JUX	Day Year 205	3 32 40 PM	
was a	Examin		4a. Facility Name (If not institution, give	th	4c. County of Deat	h				
an.	Funeral Director		1447872 145717 5. Social Security Number 6. So 151-26-9605		st birthday) If U Yrs. Mor	BACTIMORE nder 1 Year   If Under 24 Hrs ths Days Hours Min		9. Birt (, Year), Cq	hplace (State or Foreign	
	and ww		Usual Residence of Decedent  10a. States 10b. County	10c. City,	Town or Location		•		10d. Inside City Limits	
	Maryl.	by Funeral Director	MD Ann A	rundel H	anove	r			1 Yes 2 □ No	
)36 	th with the 23a or 28a		10e. Street and Number Rother	ham Drive	101	21076		10g. Citizen of What Co	untry?	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanther stutt be neithed at once.		11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	<u> </u>	ecedent of Hispanic Origin? (specify Cuban, Mexican, Puess 21) No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White Specify:		
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	e filed al Hygi I other vent,	. To Be C	17. Father's Name (First, Middle, Last)	11 1			me (First, Middle,	Maiden Surname)		
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Ma	id 2 sho Ith and 27 is ma		Informant's Name/Relationship (1	hok	196. Mailing Add	ress (Street and Numbe	ural Houte Numbe	Hanlver.	MI 21076	
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			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death.	Do not enter the	mode of dying, such as cardia	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death	
-	Physician /Medical		Immediate Cause (Final disease or condition a. Cam CAUCETZ WT METHOD A. a. Cam CAUCETZ WT METHOD A.							
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	To the vithin To the comp		29b. Signature and title of certifier	1		29c. License number		29d. Date signed (Mont	h, Day, Year)	
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	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  iNomen Attem 3001 S. HANNER ST BAGIMME IND 21225						_	
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DHMH 17 Rev 1/2001

			■ Registrar		Cer	ificate of I	Death		g. No.	8 2368	į
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	Funeral			7. Age (In yrs. I	• • • • • • • • • • • • • • • • • • • •	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. B	irthplace (State or Foreigi Country)	7
H,	Director		220-36-5291 Usual Residence of Decedent	80	Yrs.	monare Daye	Trodio IVIIII,		1, 1928	NY	
	yland iow at		10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits	_
	a-f sh	ctor	MD How	vard			Elkridge			1 □ Yes 2 No	
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	be filed within 72 hours after death with the Maryland that Hygliene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	6760 Norris Lane	2. Was Decedent Ever in U.	S 42 W	Do Docadent of III	21075	i/ V N		J.S.A.	
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Baltimore,	0 0		Burial 2 Cremation 3 Re	illoval from State		tion (Name of atory or other place		-	,		
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Albert 19:34 PM **Physician** Hamlet ,200 \$ Ö /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner A LIMOR AINI N/A 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 11 25 5. Social Security Number 6. Sex Age (In yrs. last birthday) Funeral Months Days Hours 1 X M 2 □ F 75 215-28-1592 32 Director MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show traumatic event, the Medical Examinar must be notified at XXYes 2 No Director MD Baltimore N/A 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number ŏ 2117 E. 21213 USA Preston Street items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 Married ō 1 □Yes 2 No Specify Specify: Black <u>\$</u> 3€Widowed 4 □ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) various Truck Driver 12th N/A is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard ပ Henry Pitts Henrietta Coleman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is 1 any injury or other traul once. Annette Howell-niece 6746 Ransome Dr. Gwynn Oak, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Carmel Cem 20c. Location - City or Town, State 20a, Method of Disposition Date 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/24/08 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARCH FUNERAL HOME-EAST 21. Signature of Funeral Service Licensee 1101 E. North Avenue Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lhour ACUTE MYOCARDIAL Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 15 years DATHEROSCLEROTIC VASCULAR DISERSE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown CHRONIL REMAL FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an certificate has birector, page 2 sl PULMONARY FIBROSIS autopsy 2/2 No 1 ☐ Yes CARDIOMYOPATHY director. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

requires that the death certificate be executed Records, P.O. Box 68760 ospital or Attending I hours after death.

death with

filed within 72 hours after

Pages 1 and 2 should be

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Baltimore, Maryland 21215-0036

the Funeral Director; Aff npletely the within To the

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After t

State Registrar

(Check only one)

Grome

31. Date filed (Month, Day,

29b. Signature and title of certifier

and manner stated.

Registrar's Signature

Auster no

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SNYDER M.D

Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

2264F

900 SOUTH CATEN AVENUE BALTIMORE, MARYLAND 21229

29d. Date signed (Month, Day, Year)

JULY 10, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death QDP M Month Dav Year Joseph Hajek 18 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death HARFOR (CA) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1**7** M 2 □ F Months Days 94 212-07-6035 02-13-1914 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 USA 3604 Abingdon Beach Rd 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business n Elementary/Secondary (0-12) College (1-4or 5+) 12 Bata Shoe Co Chief Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adela Zeleny Benard Hajek 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Drapinski (Granddaughter) 1532 Deerfield Rd Darlington, MD 21034 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Male Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07-21-2008 Bel Air, MD Bel Air Mem. Gard. 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Dans Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nevmonia Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Myverdin 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

certificate be executed burial-transit and Box 68760, attending physician the as use for ned by the at edetached for Division or Vital Records, P.O. has

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Examine completely filled in by the funeral director, within 24 hours after death.

To the Funeral Director: After To the Hospital c

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at show

r than "natural", or items 23a or

and Mental Hygiene.

or other traumatic event,

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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death with the Maryland

within 72 hours after

Baltimore, Maryland 21215-0036

Physician/Medical Completed Be ပို Certification:

29a. Certifier

(Check only one)

Medical

State Registrar

29d. Date signed (Month, Day, Year)

29c. License number 29b. Signature and title of certifier

1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

machail no

31. Date filed (Month, Day, Year) JUL 2 3 2008

Theodore M. King, Jr., MD. 31. Date filed (Month, Day, Year) State Registrar

32 Registrar's Signature

Assistant Medical Examiner

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12152000 Mogth Gerald Dennis Jackson Sr. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b\_City, Town, or Location of De ALTIMORE N/A Date of Birth (Month, Day, Year)
10 16 49 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 □ F Months Days Hours Min. 219-50-3110 Yrs MD 59 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County M∑Wes 2 No Baltimore N/A MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21214 USA 6411 Laurelton Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 🗓 No Specify. Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Overhead Lineman  $A \setminus N$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Snowden Jackson Betty Benson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6411 Laurelton Avenue Baltimore, MD 21214 Estherlita Jackson-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N☐Burial 2 ☐ Cremation 3 ☐ Removal from State 7/28/08 Baltimore MD Greenmount Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityMARCH FUNERAL HOME-EAST 1101 E. North Avenue Baltimore, MD 21202 Warre Approximate
Interval Between
Onset and Death
JAMASW N 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) awle myocardial Due to (or as a consequence of): Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2ER/Outpatient 1 Inpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

Examiner The law requires that the death certificate be executed burial-trar and physician the as nse for Records, page 2 should After this certificate has been ision or Vital Hospital or Attending Physician: funeral director.

Physician/Medical Examiner Completed by Be Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

Director

Funeral

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Completed

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death with the Maryland

r. Pages 1 and 2 should be filed within 72 hours after dea time to the earth and Mental Hygiene.

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Pages 1

Department or Important: If any injury or

**Physician** 

/Medical

3altimore, Maryland 21215-0036

25. Was case referred to medical examiner? 1 Yes 2 No

29a. Certifier

(Check only one)

3 Suicide 4 THomicide

6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number D47353 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caton Avenue. 900 ZLCK,

Baltimore, Maryland

State Registrar

31. Date filed (Month, Day, Year)

2008

and manner stated.

within 24 hours af er death.

To the Funeral Director:

filled in by

completely

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 18, Physician 2008 7:00 p D. Jones Robert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Charlestown Care Center Catonsville 8. Date of Birth (Month, Day, Year) 28 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min. 1**X** M 2□F Illinois 475-26-1234 79 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10h County 10d. Inside City Limits Catonsville Maryland Baltimore 1 ☐ Yes 2 ☐ XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Ln., HV 322 21228 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) USAF Master Sergeant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Jones Selma Frederick ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 Maiden Choice Ln., HV 322, Catonsville, MD 21228 A. Mildred Lamp (Companion) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/22/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uiseas or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 5 Pending investigation 1 Anaturai 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

the death certificate be executed burial-transi and Division or Vital Records, P.O. Box 68760, physician the as ding ned by the at e detached for peen has page 2 s certificate

**Funeral** 

Director

Id 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Health em 27 I

permit. Pages 1 Department of H Important: If ite any injury or ot

Physician

Examiner

/Medical

3altimore, Maryland 21215-0036

Physician/Medical ģ Completed Be 2

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir or Attending Hospital within 24 hours a To the Funeral I

State Registrar

Medical

Name and address of person who completed cause of death (Item 23a) (Type, Print) 1152 31. Date filed (Month, Day, Year)

4 Homicide

29b. Signature and title of certi

29a. Certifier

32. Registrar's Signature

and manner stated.



**ORIGINAL** 

19100

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 3:50 PM 2008 Jordan Ethel Mae /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Memorial Hospital N/A Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. 245 42 3499 Director Sept 17,1932 N.C Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location r items 23a or 28a-f show item rust be notified at Director 1 √Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1733 E. Funeral Baltimore St. 21231 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If iten 27 is marked other the any injury or other trainer. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify. ≥ XX Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Taney Town Eiementary/Secondary (0-12) College (1-4or 5+) Deli Laborer llth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Miles ပ Richardson Louise 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Billie Holiday Ct. Apt 303 Balto, MD21205 Charlie Jordan/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State TRINITY CEMETERY July 29,2008 BALTO, MD. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service 1008 SCRUGGS FUNERAL HOME PRESTON ST. BALTIMORE, Md 23a. Part 1. Enter the disease, or complications that cause death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Respiratory **Physician** days /Medical Due to (\*r as a conservence of): Examiner heymonta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-trar Box 68760圣 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 No Month Day Year 4 ☐ Pregnant at time of death signed by the a d be detached for 5 ☐ Other (specify) P.0. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Physician: The certificate 1 ☐Yes 2 ☐No 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending within 24 hours after death,

To the Funeral Director: A

completely filled in by the fu investigation 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number AT 2438946 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M-0

DHMH 17 Rev 1/2001

Registrar

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ymand 31. Date filed (Month, Day, Year)

JUL 2 3 2008

Memorial Hospital Baltimore MD21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Şignature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 19 2008 segsler /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bon Secours Baltimore 8. Date of Birth (Month, Day, Year) 9/ Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1,1935 South Carolina 1 X M 2 □ F 247-56-6576 Director 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 □ No Director more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any righty or other traumatic event, the Medical Examines ones. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 Black Completed by 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ 19a. Informant's Name/Relationship (Type. Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 125/2008 4 ☐ Donation 5 ☐ Other (Specify) VODA Cemeter 21. Signature of Funeral Service Licensee 22. Name and Address of E-cility W. North A Fu 23a. Part Enter the digease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shd it, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi - Cause (Final disease or condition resulting in death) Piul monary
Due to (or as a consequence of): minutes Physician /Medical Examiner Due to (or an econsequence of): Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed hypertension
Due to (or as a consequence of): physician and s the burial-trans Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Donknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an physema autopsy 1□ Yes 2 PN 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NER/Outpatient 3 □ DOA 1 | Inpatient Certification: To 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier augunding Physician Cont

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Marcia Cort IND 31. Date filed (Month, Day, Year) State Registrar

2000 W. Baltimore Street, Baltimore MD 21323 Secours MUSPITEL 32. Registrar's Signature 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008

		•	For State Registrar		State of t	viai yiai i	Cer	tificate of	Death	and w	entai myt	leg. No.	008	23689			
	Physicia		1. Decedent's Nam		<sup>ast)</sup> Eva Virgir	nia Joh	nson				2. Date of Dea Month		008 <sup>Year</sup>	3. Time of Death 4:55 A M			
	/Medic Examin		4a. Facility Name (		ive street and number			4b. City, Town, o	or Location o			4c. Co	unty of Deatl <b>Ba</b> l	timore			
*	Funeral Director		5. Social Security N	Number 6.		Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Apr	Yea <i>r)</i> 8, 1917	9. Birtl	nplace (State or Foreign untry) MD			
	0		Usual Residence of 10a. State			10c. City	y, Town or Loc	cation						10d. Inside City Limits			
	8a-fs	Director	MD		altimore			105 75 0-1-	Caton	isville		10a Citizon	of What Co	1 □ Yes 2 No			
	3a or 2	al Dir	10e. Street and Nu	Manor Dr.				10f. Zip Code	212	228		rog. Citizer		S.A.			
020	illed within 7.2 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be mothed at	by Funeral	11. Marital Status	ried 2 Married	12. Was Decede Armed Force 1  Yes 2 If Yes, Give Year or Date	es? No		Vas Decedent of fYes, specify Cub I ☐ Yes 2 No		gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	1	Race - Ame Black, White ecify:				
0-612	on 72 no o. in "natur Mudical	Completed	(Spe	15. Decedent's ecify only highest o	Education grade completed)	or 54)	(Give	OO NOT use retire	rk done during most of working se retired)			16b. Kind					
7	Hygiene Hygiene Her tha		17. Father's Name	8				Sch	ool Syst		School System ame (First, Middle, Maiden Surname)						
ב ב	fig be if fental F rked ot tic ever	To Be	17. Fathers Name	(First, Middle, La	George	King			a 3 Manie			e Cross					
nar y	z snou n and N is mar raumat			Name/Relationship	(Type. Print)				Address (Street and Number or Rural Route Holly Manor Dr. Catonsville, I								
altillore, i	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If teem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Microal Examinar must be notified at once.		20a. Method of Dis 1 D Burial 2		☐ Removal from Sta		Place of Disportence of Place of Disportence of Dis	sition (Name of natory or other pla	ace)	С	25, 2008		ion - City or	Town, State			
	permit. P Departm Importal any Injui		21. Signature of F			Mols	22	Name and Addr	ess of Facility	y Home, nbia Pi	P.A. ke Ellicott	City, MD	21043				
E	hysician /Medical /Medical sixaminer / was prize partial - transit e purial - transit e p	edical Examiner	Immediate Cause disease or condition resulting in death)  Sequentially list or if any leading to ir cause. Enter Und Cause (Disease o that initiated event resulting in death)	onditions, mmediate lerlying or injury ts	b. Due to (or	as a consequ	s a consequence of):  s a consequence of):  s a consequence of):							Onset and Death			
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US, T	signed b	þ	Part II. Other sign	ificant conditions	contributing to deat	h but not resi	ulting in the ur	nderlying cause g	iven in Part I.			Did tobacco use contribute to the cause of death?  I Yes 2 No 3 Probably 4 Hundre					
al necords,	i, rite tas bee cate has bee page 2 shou	Completed								<u> </u>	24a. Was autor perfo 1 □ Yes	rmed?	prior to death?	utopsy findings available completion of cause of			
vision or vital	To the hospital or Attending Frigstrant, the law requires that beant certificate be executed.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Certification: To Be	25. Was case referencements?  1 Yes 2 2  27. Manner of Dea 1 Natural 2 Accident 3 Suicide 4 Homicide	<b>3</b> 440	28a. Date of (Month,) ion be 28e. Place of	Injury <i>Day, Year)</i>	M 1 □Yes 2 □No					dence 6 Dother (Specify) Hospice					
5	hours after the state of the st		29a. Certifier (Check only	1 Certifying	Physician: To the beaminer: On the bas	est of my kno	wledge, deat	h occurred at the	time, date ar	nd place,	and due to the	cause(s) a	nd manner a	s stated.			
ode L	thin 24 the Ft	Medical	one) 29b. Signature and		aminer: On the bas and manne		and/of In			attr occur	at the time,						
	0 <b>1</b> €		. //	7	& ind	]		00061199				29d. Date signed (Month, Day, Year)  TUly, 20, 2008					
	Sta	te	30. Name and add	dress of person wh	o completed cause	of death (Iten	n 23a) (Type, Non Pu	Print) Charle	55.	7 1	vite	209	, Tows	July 140 21208			

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	DI		Decedent's Name (First, Middle, Last)		_		2. Date of Dea		Year	3. Time of Beath			
	Physicia /Medic		Mamie H. Killebrew				June 30	, 200	08	6:20 P M			
8	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or				ounty of Death	_			
		BŲ,	Heartland Nursing Home  5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Hyatts	If Under 24 Hrs.	8. Date of Birth	1	ince Ge	orge's  place (State or Foreign  intry)			
	Funeral Director		223-07-2913 1□M 21€F	91 Yrs.	Months Days	Hours Min.	(Month, Day Aug. 12			th Carolina			
	bug w		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or Loc	cation					10d. Inside City Limits			
	Maryla f sho led at	JO.	District of Columbia	Washing	gton					1 TYes 2 □ No			
	r 28a- notif	Director	10e. Street and Number		10f. Zip Code			10g. Citize	n of What Cou	intry?			
	th with		3298 Fort Lincoln Drive, N	NE #429	20018				ed Stat				
	r dea	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	. 14	. Race - Amer Black, White				
36	be filed within 72 hours after death with the Maryland to Hyglene. did bylyglene. did they than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ N If Yes, Give 1 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1	I□Yes 2☐No	Specify:		S	pecify:	Black			
5-0036	2 hou latura cal E	ted	15. Decedent's Education	16a. Deced	lent's Usual Occupa kind of work done of	ation	16b. Kind of Business/Industry		ndustry				
72	within 7 liene.  than "n the Medi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5-	— life. D	OO NOT use retired	)	ng .						
7	filed wi Hygien ther th	Co	12 years	Sa	ales Pers		/Eiret Middle		vate				
Maryland	iould be fil I Mental H narked oth	Be	17. Father's Name (First, Middle, Last) Willie L. Harrison				's Name (First, Middle, Maiden Surname) tta Hedgepeth						
Ĕ	rd 2 should be the and Men the and Men 27 is marked traumatic to	ပ္	19a. Informant's Name/Relationship (Type. Print)	19h Mailin	a Address (Street a				Town. State. Z	in Code)			
<u>8</u>	and 2 s ealth an n 27 is i er trau		Donald R. Killebrew, Sr Son 3298 Ft. Lincoln Dr., NE #429 Washington,										
Ţ.	of H		20a. Method of Disposition	20b. Place of Dispos cemetery, cren	sition (Name of natory or other plac	e) :	Date	20c. Loca	ation - City or 1	Fown, State			
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Baitimore,	permit. Page Department ( Important: If any injury or once.		21. Sunature of Funeral Service ticansee	. 74 14	. Name and Addres								
	EU = 8 0		23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximately all the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval B										
	Physician		shock, or heart failure. List only one cause on each line immediate cause (Final	e. opulmonary		g,	,,			Interval Between Onset and Death			
	/Medical		reculting in death)	consequence of):									
	Examiner		Sequentially list conditions b. Myocar	dial Infar	rction								
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Box	eath certifi attending for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome past 1 □ Live birth	2 ☐ Fetal death 3 ☐	Ectopic pregnancy			23	ld. Date of deli Month	very Day Year			
	The law requires that the death cert te has been signed by the attending tage 2 should be detached for use a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	time of death 5□	Other (specify)					22,			
Р.О	res that the de signed by the a be detached t		Part II. Other significant conditions contributing to death but	t not resulting in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco use	e contribute to	the cause of death?			
Vital Records,	w requires been sigr should be	ed by					10	Yes 2x	No 3□Pr	obably 4 □Unknown			
ပ္ပ	law re as bee 2 sho	Completed					24a. Was		24b. Were au	topsy findings available completion of cause of			
<u> </u>	(G C)	Com					perfo	rmed?	death?	2 No			
Z E	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner?		t 3DDOA Othe	26. Place of Deat			_				
ō	<b>hy</b> this al d	To	27. Manner of Death 28a. Date of Injur		" JU DON	4 LA Nursing Fig	me 5 ☐ Resi 28d. Describe			cify)			
<u>o</u>	inding Path.	atior	1 ⊠Natural 5 □ Pending (Month, Day 2 □ Accident investigation	Year) Injury		Yes 2 □ No							
Division or	l or Attendate death Director	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of inju building, etc	ry - At home, farm, stro . (Specify)	eet, factory, office		28f. Location ( City or To	Street and vn, State)	Number or Ru	ıral Route Number,			
	spltal ours at neral Deral Cilled		29a. Certifier 1 Certifying Physician: To the best of	f mv knowledge, death	h occurred at the tir	ne, date and place.	and due to the	cause(s) a	and manner as	stated.			
	Fur 4 h	edical	(Check only one) 2 Medical Examiner: On the basis of and manner sta	examination and/or in									
	To the within 2 To the complet	Me	29b. Signature and tide of certifier		29c. Licens	e number			signed (Monti				
)	8	D46529 July 7, 20							008				
2	(3)		30. Name and address of person who completed cause of de Victor Onyejiaka 7325A Har			belt, MD	20770						
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registra		- 7	,							
	Registr		JUL 1 0 2008 Know &	DOBOTE !									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 23691 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** RUSSELL ELMER KELLY 2008 /Medical JULY 13, 7:35 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOSEPH RITCHIE HOSPICE BALTIMORE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Year If Under 24 Hrs. **Funeral** Days Hours 1**X** M 2□ F Director 260-31-5875 56 DEC. 3, 1951 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 TXYes 2 □ No Director MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? <sup>10</sup>JÖSEPH <sup>N</sup>KTTCHIE HOSPICE 828 N. EUTAW ST. Funeral 21201 Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 "natural", or WHITE 1 ☐ Yes 2 X No Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER unk SELF EMPLOYED is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental F ပ unk MARGARET JONES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2 short of Health and : If item 27 is n TRACY L. BROWN/FRIEND 817 ST. PAUL ST. - APT. #203, BALTIMORE, MD 21201 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department or Important: If injury 4 ☐ Donation 5 ☐ Other (Specify) 07/17/2008 | HANOVER, MD ARDENT 21. Signature of Funeral Service Licensee 22. NZOO7-09 EASTERN AVE., BALTIMORE, MD 21231 m01358 WESLEY CHAVIS, JR. FNRL. HM 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): cancer /Medical Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Due to (or as a consequence of) 68760. physician Physician/Medical Box esn If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for t in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) the Ö 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 1∐ Yes **Division or Vital** Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 No 1 ☐ Yes P 1 Inpatient 2 ER/Outpatient 3 DOA 6 Wother (Specify) 17050100 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the

State Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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32 Registrar's Signature

ND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

26Binson

2008

29c. License number

29d. Date signed (Month, Day, Year)

EY HOW STREET Baltimers, MARY IGN &

08-05473 Robert F. Kidwel	I, Jr	Please Type State	or Print in Blace of Maryland / I	<b>ck Indelik</b> Departme	ole Ink. E	E <b>nsure</b> Ith and	All Co Menta	<b>pies Are</b> I Hygiene	Legib			
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		3 Widowed 4 Divorc	1 Yes 2 A	2 X No		2X No	specify:			Specify:	White	
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Box 68760 e death certificate b the attending physical for use as the bu	2	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregnancy	Fetal death	n 3	Ectopic p	regnancy		23d. Date of deliv Month	ery Day Year	
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State Registrar

DHMH 17 Rev 1/2001
OCME 2006

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32 Registrar's Signatu

Russell Alexander MD.

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

July 17, 2008

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2008 Certificate of Death First, Middle, Last 1. Decedent's Name (F. 2. Date of Death 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Northwest Hospice
5. Social Security Number 6. Sex <u>Randallstown</u> Baltimore Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Days 1**X** M 2□ F Months Hours Min Director 89 Oct 29, 1918 218-10-2617 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD 1 ☐Yes 2 ☐ No Director Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue #A213 USA 21784 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 141— 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iten any injury or other traumatic event, the Waltest Evaripas. Once. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. white þ Specify. 3 Widowed 4 □ Divorced 41-42 Completed 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com grade completed (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) engineer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martha Ellen O'Neal William Keir ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13907 Longnecker Road Reisterstown, MD Duncan Keir/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town. State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Fundal S State Anatomy Board 655 W. Baltimore Street wade, Director Baltimore, MD 21201 23a. Part 1. Enter the disease, of complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any hadding term clark cause. Enter Underlying Cause (Disease or injury that initiated events. Examine Due to (or as a consequence of) that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Ye ar 5 Other (specify) signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy perfor 1 ☐ Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Of pice this c 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Dea 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 No I Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

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Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ause of death (Item 23a) (Type, Print)

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Mair St Klistentown, MD 21136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Mary Jeanette Lutsche 12 35 P M JULY /Medical 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE ST. AGNES HOS DIT AL 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 1 □ M 2X F Days Yrs 86 Director 02/03/1922 Baltimore, MD <u>217–12–7872</u> Usual Residence of Decedent the Maryland a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 715 Maiden Choice Lane PV301 23a 21228 event, the Medical Examiner hust United States Funeral items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ∐Yes 2 **X**No 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 9 If Yes, Give Year or Dates: 1 ☐ Yes 2 ▼No Specify: White Completed by Specify: 3 □Widowed 4 □ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) in and 2 should be fill Health and Mental H tem 27 is marked oth Be Frank M. Williamson Ella Kuhl ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. Mrs. Janice L. Shriver (Daughter) 6212 Groveland Road, Linthicum, MD 21090 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Meadowridge Gardens 07/25/2008 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) NEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760. the attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy for Month Day Year 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has WITH HUDRONEPHROSIS autopsy The performed? 1 ☐ Yes 2 No 2 🗌 No 1 ☐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Division of Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29c. License number 29b. Signature and 29d. Date signed (Month, Day, Year) 200% person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of St. Agrus Kospital 32. Registrar Signatura DESM, MO 900 CATON AVE BALTIMORE 21229

Registrar

31. Date filed (Month, Day, Year

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Registrar DHMH 17 Rev 1/2001

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32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AW AN

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2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Da 7-22-2008 3:30A M Elinor Catherine LeBrun 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Balto. Glen Meadows Glen Arm If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign Country)
New York 6. Sex 7. Age (In vrs. last birthday) Days Hours 1 □ M 2 🗓 F Yrs 3-30-1918 109-07-0470 90 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2√ No Md. Balto. Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11630 Glen Arm Road 21057 USA 12. Was Decedent Ever in U.S. Armed Forces? 1X□Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Specify: 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Lynch Anna Dahl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9412 Banff Terrace Chesterfield, Virginia 23838 Richard LeBrun 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date St. John's The Evangelist 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5-2008 Hydes 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek FunerAL Home u 9705 Belair Rd. Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Queet and Death Immediate Cause (Final presno vascular disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions One to for as a consequence off If any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Box 68760. P.0. Division of Vital Records,

Physician: The law requires that the death certificate be executed burial-transit and physician a the burial attending ph signed by the a d be detached f peen cate has by page 2 s certificate this certific al director, After thi Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

**Physician** 

/Medical

Director

Funeral

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Completed

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Certification: To

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29a. Certifier

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanina, must be notified at once.

Physician

/Medical

Examiner

3altimore, Maryland 21215-0036

Registrar

28a. Date of Injury (Month, Day, Year) 5 ☐ Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 23,2008

30. Name and address of person who completed ause of death (Item 23a) (Type, Print)

2008

Colline Ma 2204

CoBM MO N Charles mI 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 23697 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Earnest K. Long 21, 2008 July 11:12pm<sup>V</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 600 Kalorama Road Sykesville Carroll 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Funeral 1 M 2 □ F Months Days Hours Min. 67 10, Director Aug. 1940 TN <u>410-62-2187</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modicel Examiner man be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 600 Kalorama Road 21784 USA 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2√□ No Specify. 2 Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lineman Utilities 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry ٥ Long Kitty Mae Collins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Betty J. Long (Wife) 600 Kalorama Road Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Springfield Cemetery 7/24/2008 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 21. Signature of Funeral Service Licenses HAIGHT FUNERAL HOME & CHAPEL, 400764 P.O. Box 195 Sykesville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
7107 - 7105 Immediate Cause (Final Physician Non-small cell disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of): physician at the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) cate has been signed by the page 2 should be detached a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 🔽 2 No 1 ☐ Yes 1 ☐ Yes Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 \sum Nursing Home 1 ☐ Yeş 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Nesidence 6 ☐ Other (Specify) After this 27. Manner of Death 1 Vatural 28a. Date of Injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death Director: 2 Accident filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760. Division of Vital Records, P.O. ō Hospital within 24 hours To the Funeral

Baltimore, Maryland 21215-0036

State

2

Registrar

Medical

29a. Certifiei

(Check only one)

29b. Signature and title of certifier

Day,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Couter Street Westminster, MD 21157 32. Registrar s

		For	State	of Marylar	nd / Depa	rtment of H	dealth a	and M	ental Hy	giene	Э			
	•	1 - State Registrar			Cer	tificate of	Death			Reg. No	200	18	23	698
		1. Decedent's Name (First, Middle	e, Last)						2. Date of De	ath		/ear	3. Time of	f Death
Physicia /Medica	- 4	Clara Gordo	on McI	ntyre					June 3	30, Da		rear	9:00	P <sup>M</sup>
Examine		4a. Facility Name (If not institution	, give street and nu	ımber)		4b. City, Town, o	or Location of	of Death		- 1	. County of	Death		
	÷.	Ft. Washington	n Health	& Rehab	Center			0			Princ	e Ge	orge'	S
Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ XF	7. Age (In yrs.		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Year,	,	9. Birthpl Coun	lace (State o	or Foreign
Director		578-28-9238	1 101 2 2	82	Yrs.				Aug 4,				h Car	olina
and •		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10	0d. Inside C	ity Limits
Aaryl f sho ed a	ō	District of	Columbia	T.T.	nahinat									2 No
r 28a-f show notified at	Director	10e. Street and Number	COLUMBIA	We	ashingt	10f. Zip Code				10a. Ci	tizen of Wh	nat Coun	try?	
23a or		3918 S Street,	SE			200	20				nited			
after death with the Maryland or items 23a or 28a-f show aminer must be notified at	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13. V	Vas Decedent of H Yes, specify Cub		gin? (Spe	cify Yes or No		14. Race	Americ	an Indian,	
after or itel	∄	1 ☐ Never Married 2 ☐ Marr	Armed F	2 📉 No				n, Puerto I	Hican, etc.)			White,		
	<u>ا ۾</u>	3 X Widowed 4 ☐ Divorced	If Yes, G Year or I	Dates:	1	☐ Yes 2 <mark>K</mark> No	Specify:				Specify:	вта	.ck	
72 hc natu lical	Completed	15. Deceden (Specify only higher	t's Education	)	(Give	ent's Usual Occup kind of work done	during mos	t of worki	na	16b. K	(ind of Bus	iness/Ind	lustry	
ithin ne. ran "	du	Ejementary/Secondary (0-12)		(1-4or 5+)	life. L	OO NOT use retire	d) -							
be filed within 72 hours after Ital Hygiene. It other than "natural", or ite event, the Medical Examine		12 years 17. Father's Name (First, Middle,	/ ant)		ј Да	ta Proce		or'o Namo	(First, Middle		rivate			
ntal Hed of	Be	Johnnie Sloan							La Pric	•	i Sumame,	,		
hould d Mel mark natic	င္	19a. Informant's Name/Relations			10h Mailin	g Address (Street					or Town C	toto Zin	Cadal	
d 2 si th an 7 is r traur				. 1						-			Code)	
1 an Healt em 2	1	Sharon N. McCr	ea – Daug	20b. J	Place of Dispor	S Street sition (Name of			ington,		_ <u>2002(</u> .ocation - C		wn. State	
ages nt of r: # #		1 ☑ Burial 2 ☐ Cremation		State	cemetery, cren	natory or other pla Cemeter		T11 T 17	8, 200			•	•	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; any Injury or other traumatic event, the Medical Exagone.	ŀ	4 □ Donation 5 □ Other (S		0.		. Name and Addre						_		
permi Depar Impor any Ir once.		Mind	out st.	1 Hrs	/ A / B / F	4001 Ben						-		9
15500		23a. Parl 1. Enter the disease, or sho k, ir heart failure. List	complications that	caused the deat		•	_						Approximat	te
Physician		Immediate Cause (Final	only one cause on Ate	each line. erioscle	erotic	Cardiova	scula:	r Dis	sease				Interval Bel Onset and	tween Death
/Medical		disease or condition resulting in death)	a	(or as a consec									years	
Examiner				(	, , .									
	je	Sequentially list conditions, if any leading to innection cause. Enter Underlying Cause (Disease or injury	D. Due to	(oras a consec	trience of):							7.		***
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cate be executed hysician and the burial-transit	dical		d											
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eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	tcome pf pregn birth 2 ☐ Feta	al death 3	Ectopic pregnanc	у			1	23d. Date Mont			Year
the a	Physician/M	1 ☐ Yes 2 😿 No 9 ☐ Unknown	4⊟Preg 9⊟Unki	nant at time of one	death 5∟	Other (specify) _								
		Part II. Other significant condition	ons contributing to	death but not res	sulting in the ur	derlying cause giv	ven in Part I		23e. Did 1	tobacco	use contrib	ute to th	ne cause of o	death?
sign d be	o o	Dementia							1 🗆	Yes 2	No 3	B ☐ Prob	ably 4 🔲	Unknown
v req	ompleted								24a. Was	on	24h W	oro auto	psy findings	available
The law	m			<del></del>					auto		pr	ior to cor	mpletion of c	cause of
	රි .	25. Was case referred to medical					00 81	- ( D 1)		2 <b>X</b> N		Yes	2□ No	
s certific	o B	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	Inpatient 2	ER/Outpatien	t 3□ DOA Oth	or:		i <i>(Check only o</i> me 5 ☐ Resi		6 DOther	(Conneile	- 1	_
iding Phys	- 1	27. Manner of Death	28a. Date	of Injury	28b. Time of	28c. Inju			28d. Describe				<i>"</i>	
nding tth. r: Afte e fun	텵	1 ☐ Natural 5 ☐ Pendin 2 ☐ Accident investig	9	nth, Day Year)	Injury		rk? ]Yes 2 □	No						
for Attendation after death.  Director: /	E E	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	in ad Zoe. Place	e of injury - At h	ome, farm, stre	eet, factory, office		2	28f. Location ( City or To			or Rura	l Route Nun	nber,
s afte	Certification:	T E TIONII SIGO	Delik	aing, etc. (opec	'97				City or 10	wii, Stat	Θ/			
		29a, Certifier Certifyin	g Physician: To th Examiner: On the	e best of my kno	owledge, death	occurred at the ti	ime, date ar	nd place, a	and due to the	cause(s	s) and man	ner as si	ated.	'e)
the H in 24 the F iplete	edical	one)	and ma	nner stated.	attori artaror irr				ed at the time.				<u> </u>	
S T Will	Σ	29b. Signature and title of certifie	7		_ 44	29c. Licens					ate signed			
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		Philip Wisots 31. Date filed (Month, Day, Year)		12070 O Registrar's Signa		Centre	#207	Wald	orf, M	D 20	602			
Stat Registra		JUL 1 0 2008		Hegistral's Sign										
			The same	15	THE PERSON NAMED IN									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2008 23699 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 21 2008 9:35p. /Medical Estelle Melton 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 9. Birthplace (State or Foreign 5. Social Security Number Richey House (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 😿 F 82 Director SC 228-32-2615 filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County Director X∑Yes 2 No Baltimore MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21213 USA 2705 E. Hoffman Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 21☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 → No Specify: 3 Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Londonfog Manufac. 12th N/A Seamstress 18. Mother's Name (First, Middle, Maiden Surname) permit, Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) Be Thomas Geneva James Canty ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey Melton-daughter
20a. Method of Disposition 2705 E. Hoffman St. Baltimore, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest p☐pBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills 7/29/08 MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST 1101 E. North Avenue Baltimore, MD 21202 OL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Caset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stz /Medical Due to ( r as a consequence of): Examiner Sequentially list conditions, if an leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-tra-Due to (or as a consequence of): Records, P.Ó. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 00 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Division of Vital completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Hospital or Attending Phys 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

10

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

2 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

stelle Meiton

DOILSCH

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 23700 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death th 2008 **Physician** Month 3:40 M SAMUEL MITCHELL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SFASONS HUSPICE BALTIMORE RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days Hours Min 218-44-7665 FEBRUSIET 15, 1944 MARYLAND Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, I've Modical Event in a rutal to additional and another. 10a. State 10b. County 10c. City, Town or Location 10d. Inside Çity Limits 1 Yes 2 No **Funeral Director** MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ALLENDALE STREET USA 21229 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: þ Specify Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. POST OFFICE ostal worver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL ALBARTA MITCHELL ပ AND MITCHELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604700 DAY MS 21207 ERIN MITCHELL/DOUGHTER WOLDEN LAUNEL CT. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CREMATORY JULY 33, 2008 HANDLES MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Services 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Ententhe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of espiratory arrest, shock, or heart failure. List only one cause on each line. Dr. However, US HOUT Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Adenocarcinoma Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to him class cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an ours after death.

leral Director: After this certificate has, filled in by the funeral director, page 2 s autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) SLASOWS Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSP LC 1 ☐ Yes 2 🕍 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 🗖 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier within 24 hor To the Fune and manner stated.

State Registrar 29b. Signature and title of certifier

I relliah I Kense

Dobwah 31. Date filed (Month, Day, Year)

JUL 2 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

H45931

25 MAIN STREET REISTENSTOWN MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 16, Day 2008 Year 3:00 PM M **Physician** June Ray Myers /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 5612 Sonoma Rd. Bethesda Date of Birth (Month, Day, Year) 06/23/1925 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Numbe **Funeral** MD Country) Months Days Hours 1 □ M 2 🗷 F 83 Director 579-24-4365 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐Yes 2 No ed other than "natural", or items 23a or 28a-f shevent, the Wedical Examinar and be potified Director Bethesda Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20817-5612 Sonoma Rd. Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 No 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Ş Q Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Own Home al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental H Be Mabel Julia Berry Eleazar Rav ۴ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: if item 27 Is any injury or other trau once. 1601 18th St. NW #902 Washington, DC 20009-Robert B. Myers, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Jul 18 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Rapp Funeral & Cremation Services 21. Signature of Funeral Service License M00382 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Heart 1000 /Medical resulting in death) Due to ( as a consequence of) Examiner emonezen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit be executed MOKIL Due to (or as a consequence of): physician at the burial P.O. Box 68760, Physician/Medical been signed by the attending p should be detached for use as IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 The law requires 1 es 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performe certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division (Month, Day, Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar 29b. Signature and title of certifier

ne and address of person who completed cause of death (Item 23a) (Type, Print)

10215

32, Registrar's Signatur

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Feanwood Rd, Bethesda, Manyland 2087,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** John Thomas Michael P 07-18-2008 621 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 □ F 68 Director Conn 046-30-4646 08-15-1939 Usual Residence of Decedent after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 27 No Director SC Myrtle Beach Horry 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29588 USA 8421 Tartan Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White ş 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vera McCaffrey John Michael 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S permit. Pages 1 and 2 Department of Health a Important; If Item 27 Is any injury or other trat once. 8421 Tartan Lane Myrtle Beach, SC 29588 Donna C. Michael (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 07-22-2008 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licenses Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to for s a consequence of). /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ISTOLE and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Hostic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No 2 ER/Outpatient 3 □ DOA 2 1 Inpatient 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 □ Yes 2 □ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) au) 30. Name and address of pers maho completed of the of death (Item 23a) (Type, Print) 500 upper Chesapeake Dr. Beldir, mo 2/014 Barrueto

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2008 2. Date of Death

**Physician** /Medical Examiner

Funeral Director

a or 28a-f show the notified at "natural", or items 23a must Examiner the Medical than, Health and Mental Hygi em 27 is marked other permit. Pages 1 and 2: Department of Health at Important: If Item 27 is any injury or other trauonce.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

Division or Vital Records, 40, 186x 68760, page 2 should director,

or Attending Physician; To the Hospital of within 24 hours at To the Funeral D

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23703 1. Decedent's Name (First, Middle, Last) JULY Y MORAN JOSEPH 4.19 PM 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HARBOR HOSPITAL. BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sev 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 → M 2 □ F 78 216 24 8439 10/06/1929 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Anne Arundel Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 - 16th Avenue 21225 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 10/ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ▼Yes 2 No 1947—
If Yes, Give
Year or Dates: 1951 Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify. þ 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 vears Draftsman Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Bertram Moran Dorothy Zeberlein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John P. Moran / Brother 106 - 16th Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify)

21. Signature of Superal Service Licensee Bayview Crematory 07/25/2008 Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 14 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Pal 1. Enter the disease, or some lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASPIRATION Due to (or as a consequence of): CANCER LUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD RES-001 JULY 20 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S. HANOVERST, BALTIMORE, 21225 SHEENU SHEELA

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Grante

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23704 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Calvin 21, 2008 R. Mathis Ju1y 18:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ₩ 2 □ F Director 213-36-7826 69 Feb. 22, 1939 MD Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at MD Carrol1 Director Westminster 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2750 Murkle Road Funeral 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify: þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) <u>Police Officer</u> Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental I Lon Mathis Rubv Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health al Important: If item 27 is any Injury or other trau Mr. Jeffery Mathis (Son) 2750 Murkle Road Westminster, MD 21158 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem Park 7/25/2008 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, P.A.
PO Box 195 Sykesville, MD 21784 MO0764 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betv Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to lo s a consequence of): Examiner cohal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent e of) Examiner certificate be executed -transit 21/105/5 and Due to (or as a consequence of) Box 68760, burialphysician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death 3 ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2: autopsy performed certificate 1□ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Other: 2 1 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft thin 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29d. Date-signed (Month, Day, Year)

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Store

Registrar's Signature

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month AM 8:j0 MITCH /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** ANNE ARUNTEL -12 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours 69-18-7098 1₩ M 2□ F Director NNSYLVANIA Usual Residence of Decedent death with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the "had call Experiment must be realled at 1 ☐ Yes 2 No Director 0 Thier TUNC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 040 .5 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☑Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) tEDERY! SPECIALIST ADMINISTRATIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be be CHARLES W. MITCH Pages 1 and 2 should 1077 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trau Once. WILLIAM MCCREATY RESSTONED, ARNOLD, MO 125C 21012 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State -18-08 HANDVER MO. 4 ☐ Donation 5 ☐ Other (Specify) REMATORY 22. Name and Address of Facility 21. Signature of Funeral Service License MANERTY FAMILY FUNERAL HOME PASADENA, MD. Z1122 ZLOI MOUNTAIN RT. Part I. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each lin. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, bading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical signed by the attending place as detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ne 24a. Was an page 2 s has autopsy performed? certificate 1 □Yes 2 4No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 | Yes 2 | 1 | Ho ၉ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 6 Dether (Specify 27. Mann Death 1 Matural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

P.O. Division of Vital Records, within 24 hours a Hospital

ours after death.

Neral Director: After this certific filled in by the funeral director, Certification: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner faced. 29a. Certifier Medical (Check only one) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

Eliott dorbayy mp y y mud 100 MP dorbary 1JON 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar **ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Physician Month 21, Gracie Marks July 6:25pm /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Gilchrist
5. Social Security Number Center Baltimore Hospice Towson
If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 □ M 2 □ 4F Months Days Hours Min. Aug. 25, 1926 Director 217-26-8020 Va Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Modical Experiment must be notified all 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No N/A Md Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 2831 Waldolf Ave 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ģ If Yes, Give X Year or Dates: 1 ☐ Yes 2√2 No Specify: Black Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Engineer Private Homes 12th17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Wallace Mosley Bertha Traynham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>George Marks/husband</u> 2831 Waldolf Ave. Balto., Md 21215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State LoudonParkCemeteryJuly28,08Baltimore,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTO, MD 21213 ture of Funeral Service Licenson 23a. Part 1. Enter the disease, or complication's that au-shock, or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CANCER No wars disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter a control cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) PiCe 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director; 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. To the F 29d. Date signed (Month, Day, Year)  $\int \int (\gamma 2, 2, 2008)$ 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Church St. Balts and Zc 20x Eley 6701

Registrar DHMH 17 Rev 1/2001

State

2. Registrar's Signature

3 2008

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31. Date filed (Month, Day,

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day **Physician** Year SMIN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death 1156 Ward Street Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 5 Hours 6 Min. 54 1 ☐ M 2 🔀 F Director None 07-15-2008 Maryland Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1XXYes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1156 Ward Street 21230 Funeral United States "natural", or Items dical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 No Specify. Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Infant N/A is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Dylan Barron, Sr. ဂ္ဂ Shirley Ann May 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Shirley A. May - Mother 1156 Ward Street, Baltimore, Maryland 21230 injury or other permit. Pages 1 an Department of Heal Important: If item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July NXBurial 2 ☐ Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 24, 2008 Elkridge, Maryland Meadowridge Mem. Pk. 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service Licenses M00053 MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably ∃Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes performe

Physician /Medical **Examiner** 

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

1 and 2 should be

To the Hospital or Attending Physician: The law requires that the death certificate be executed

After

Division or Vital Records, P.O. Box 68760,

Director; filled in by the

Be

Certification: To

cal

25. Was case referred to medical examiner?

1 🗌 Yes

27. Manner of Death 1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of o

2 No

24 hours a within 24

State Registrar

1 Inpatient

(Month, Day Year)

28a. Date of Injury

and manner stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

26. Place of Death (Check only one

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 No

30 Name and addry's of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 23

5 ☐ Pending investigation

6 Could not be determined

ER/Outpatient

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

3□ DOA

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 7:10 AM Jul 22, 2008 Francis A. McCullough, Jr. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Howard Woodstock 10356 Old Frederick Rd. If Under 1 Year Months Days 5. Social Security Number Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2□ F Hours Director 212-14-7610 85 MD Mar 23, 1923 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show "natural", or items 23a or 28a-f shovidical Examiner must be notified at 1 ☐ Yes 2 No Director MD Howard Woodstock 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 10356 Old Frederick Rd. Funeral 21163 12. Was Decedent Ever in U.S. Armed Forces? 1 Dyes 2 □ No If Yes, Give Year or Dates: 11/4 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married 1/25/1943 Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White 11/4/1945 Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) printing press mechanic U.S. Government permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygis Important: If item 27 Is marked other any injury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis Albert McCullough Sr. ပ Mary Eleanor Murphy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth McCullough Spouse 10356 Old Frederick Rd. Woodstock, MD 21163 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) Jul 29, 2008 Glen Burnie, MD Atlantic Crematory, LLC 21. Signature of Funeral Sprvice Licenses 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury a correquence of) Examiner The law requires that the death certificate be executed and that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of) as the burialattending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Completed by should be 2 □ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an has page 2 autopsy certificate or Attending Physician: ector. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 200 Other: 4 Nursing Home 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Sesidence 6 ☐Other (Specify) Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 1 Natural (Month, Day Year) Injury 5 Pending 2 Accident М 1 ☐ Yes 2 ☐ No investigation hin 24 hours after death the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

S

and

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Re

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strar's Signature

Hospital

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

200

Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

## Facility Name (if not institution, plus streams and number)  ## Foundary    Projector	
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Virgil Grant Mercier   19a. Informant's Name/Relationship (Type. Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Vernon N. Mercier, Jr. Son  3531 Split Rail Lane Ellicott City, MD 21042  20a. Method of Dispsfellon 1	
Vernon N. Mercier, Jr. Son   3531 Split Rail Lane Ellicott City, MiD 21042	
Committee   Comm	
23a. Part 1. Emer the distance, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Physician (Medical Examiner)  Physician (Medical Examiner)  Sequentially list conditions, if any, hacking to liminediate cause. Enter Underlying Cause (Disease or ronging to liminediate cause. Enter Underlying to liminediate cause (Disease or injury that initiated events resulting in death) Last  Pure to (or as a consequence of):  Due to (or as	
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d.    FFEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Yes   2   No   9   Unknown   23d. Date of delivery   Month   Day   Mont	
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The FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown  23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   4   Pregnant at time of death   9   Unknown  23d. Date of delivery   Month   Day  And And And And And And And And And And	
9 Unknown 9 Unknown 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of	
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24a. Was an autopsy findings autopsy prior to completion of	Linknown
24a. Was an autopsy findings prior to completion of death?  25. Was case referred to medical examiner?  1   Yes   2   No    25. Was case referred to medical examiner?  1   Yes   2   No    26. Place of Death (Check only one)  27. Manner of Death  28a. Date of Injury  (Month, Day, Year)  28b. Time of Injury at Work?  28c. Injury at Work?  28d. Describe how injury occurred	available
1 ☐ Yes 2 ☐ No  25. Was case referred to medical examiner?  26. Place of Death (Check only one)	available
Hospital: 1 Inpatient 2 ER/Outpatient 3 DCA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	available
27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Work?	available
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	available cause of
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	available cause of
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Charles Sheehay 102988 Botto. Nati, Pike 21042	available cause of
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	available cause of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene FH g881 7/23/08 TT Certificate of Death

Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 4c. County of Death 5119 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner AGNES HOSPITAL JUSIAS more 9 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days 1XM 2□ F Director outh Usual Residence of D filed within 72 hours after death with the Maryland 10c. City, Town or Location Catonsville 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director More 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 □ Divorced 100 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) STEE بخ، Marylant.

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permit. Pages 1 and 2 should be file.
Department of Health and Mental Hiller
Important: if them 27 is many injury or other
once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည 19a. Informant's Name/Relationship (Type. Print) (doughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 2008 22. Name and Address of acility

OSE OH L. RUSS

2.22 W. NOTTH 21. Signature of Funeral Service/Licensee Έ Ave. 23a. Parti Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician HTUOM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 🗆 Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a, Was an 1∐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 No 2 ☐ Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P 20656 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KONSTANTIN ZUBELEVITSKIY 900 CATON AVE BALTIMORE MD 21229 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2 3 2008

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

**Physic** /Medi Exami

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene  1 - State  Cartificate of Death												
1 - State Registrar Certificate of Death Reg. No. 2008												
	1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	Day: Year	3. Time of Death				
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ier	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo	cation of Death	4	c. County of Death					
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<b>Funeral Director</b>	10e. Street and Number	. f . h . A		10f. Zip Code	. 1	10g.	Citizen of What Cou	intry?				
ā	3430 Monda	awmin A	Ve.	2/2/	6		USA					
un	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. \	Was Decedent of Hispa f Yes, specify Cuban, N	anic Origin? (Spe Mexican, Puerto	ecify Ye's or No- Rican, etc.)	14. Race - Amer Black, White					
Ž.	1 Never Married 2 Married	1 □Yes 2 No If Yes, Give		1 □Yes 2 🗓 No S	Specify:		Specify: "D	CAV				
Completed by	3 Widowed 4 Divorced	Year or Dates:	16- P	dantin Havel Oncornic		104	BI	acr				
lete	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	dent's Usual Occupatio kind of work done duri DO NOT use retired)	n ng most of worki	ing	Kind of Business/li	ndustry				
뼕	Elementary/Secondary (0-12)	College (1-4or 5+)	Cto	ol Cha	ckor	Pa	Holon	Stool Co				
ပ္	17. Father's Name (First, Middle, Last)		1010	18	. Mother's Name	(First, Middle, Maid	en Surname)	DIECI CU.	-			
Be	Roycot N	1100										
၉	19a. Informarit's Name/Relationship (7	y or Town, State, Z	in Cade)	_								
	Mc Bachina	1 L A	11 21211									
	NICS. Bernice Miller 13430 Mondaymin Ave. Exists. Ma. 2121 (20a. Method of Disposition (Name of Date 20c. Location - City or Town, State											
	1 ☐ Burial 2 M Cremation 3 ☐ Removal from State   Cemetery, crematory or other place)											
	4 ☐ Donation '5 ☐ Other (Specify 21. Signature of Funeral Service Licen	salto.	(VIa.									
	21. Signatore of Funeral Service Licen	P Pina	J6	2. Name and Address of Seph L, Ru	uss Fu	negal, H	ome, P.A					
	23a. Par 1, Enter the disease, or comp	X Williams that says and the dead	Do not ont	222 W, No	MAN.	e. Balta	D. Ma. 21	2 ( 6 Approximate	_			
	shock, or heart milure. List only of	one cause on each line.	an. Do not ent	er the mode of dying, a	ouch as caldiac	or respiratory arrest,		Interval Between Onset and Death				
	Immediate Cause (Final disease or condition resulting in death)											
	Due to (or as a consequence of):  ASPIRATION PREUMONIA											
<u>-</u>	Sequentially list conditions, if any, leading to infriedrate				_							
를	cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	,									
Examiner	that initiated events resulting in death) Last	C. Due to (or as a conseq	juence of):									
		d										
edical		.u.										
§	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of deli	very				
cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o		Dectopic pregnancy Other (specify)			Month	Day Year				
Completed by Physician/M	9 Unknown	9 ☐ Unknown										
S P	Part II. Other significant conditions of	ontributing to death but not res	ulting in the ur	nderlying cause given i	n Part I.	23e. Did tobacc	o use contribute to	the cause of death?				
귷						1 ☐ Yes	2 No 3 ₽r	obably 4 Unknown	ı			
et						24a. Was an	24b. Were au	topsy findings available	,			
Ē						autopsy performed	? death?	completion of cause of				
BeC	25. Was case referred to medical			26	S Place of Deatl	1 ☐ Yes 2 🔀 h (Check only one)	No 1 □Yes	2 No	_			
	examiner? 1 ∐ Yes 2 <b>∑</b> No	Hospital: 1 ☐ Inpatient 2 ☐	l ER/Outnatier	Other		me 5 Residence	6 ©Other (Spec	SEASONS	_			
Ë	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at		28d. Describe how in		"" Itospice	_			
atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	Work? M 1 □ Yes	2 □No							
iji	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, str	eet, factory, office		28f. Location (Street City or Town, St	t and Number or Ru	ral Route Number,	Т			
b l												
cal	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowniner: On the basis of examina	owledge, deatl	h occurred at the time,	date and place,	and due to the caus	e(s) and manner as	stated.				
Medical Certification: To	one) 2 Medical Exam	and manner stated.	adon and/or in	vesugadon, in my opin	on, death occur	red at the time, date	ario piace, ano que	to the cause(s)				
Σ	29b. Signature and title of certifier		29c. License number				29d. Date signed (Month, Day, Year)					
	Mellian exce	in		145931 July 21,20				1,2008				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												

State Registrar 31. Date filed (Month, Day, Year)

32. Rigistrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death dedent's Name (First, Midale, Last) 2. Date of Death Month Day Physician DC 50 AM 2 0 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Agras Social Security Number Himore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Jan. 5, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 215-30-8398 Hours Min. 1 □ M 2 💢 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. City, Town or Location 10a. State 10b. County 10d. Inside City Limits timore Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 USA Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Rlack ş 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use refired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Midg Be 2 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1900 Balto. Rd. Watson (Daughter ing Say 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Location - City or Town, State 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (*Specify*) 3 ☐Removal from State 21. Signature of Funera Service Li Total timore 23a. Part1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician wee kg 1032010 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1000C Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □ Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of cate has page 2 s autopsy performed? Yes 28 No death? 1 ☐ Yes certificate 2□ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No s after death.

I Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours after
To the Funeral Dire
completely filled in by Medical 29a. Certifier Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2008 Name and address of person who completed cause of death (Item 23a) (Type, Print) 3455 B66/10 BGHI More eercile

32 Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUL 2 3 2008

22/08

**Examiner** The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

Completed

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Examiner

Physician/Medical

Completed

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Certification:

29a, Certifier

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "na any injury or other traumatic event, the Mean once.

Physician

/Medical

sician and burial-trans

attending physician for use as the buria

signed by the a

certificate has been sirector, page 2 should

altimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0058290 MD 30. Name and address of person who completed sause of death (Item 23a) (Type, Print) MUTTATH 5711 S STIL SARVIS AVENUE SUITE 200, RIVERDALE MD 2073 sureshkum ar 31. Date filed (Month, Day, Year) State Registrar

**ORIGINAL** 

08-05495 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  Antonio Fernando Proctor State of Maryland / Department of Health and Mental Hygiene								
Antonio Fernando	•	- For State Certificate C		entai Hygieni	Reg. No.	200	8 2371	
Physicia Medical Examin	n/	tegistrar 1. Decedent's Name (First, Middle,Last)		Month	of Death		3. Time of Death 1330 hrs	
Wedical Examin		Antonio Fernando Proctor  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location			c. County of Death		
`		Potomac River North of Woodrow Wilson Bridge	Fort Washington			Prince George		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Ho	ours Min.	` _	Cou	nplace (State or Foreign untry)	
Birector		578-98-5069	rs.		31/196	4 Was	hington,DC	
v any		10a. State 10b. County 10c. City, Town or Loc	ation				10d. Inside City Limits	
f shov	ē	Maryland Prince George's Fort Wash	ington 10f. Zip Code		10g Cit	tizen of What Coun	1 X Yes 2 No	
with the Maryland ms 23a or 28a-f show be notified at once.	Director		20744			ted Stat		
with the same same same same same same same sam			Vas Decedent of Hispanic		s or No-	14. Race - Americ		
r death or iten	Funeral	1 Yes 2 X No	Yes, specify Cuban, Mexi		etc.)	White, etc.		
rs after ural",	اھ	3 Widowed 4 Divorced If Yes, Give Year 1 1  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed) 16b. Decedent's Education (Specify only highest grade completed)	Yes 2 No sperent's Usual Occupation (G		e 16b.	Specify: Bla Kind of Business/li		
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5-0036 iled within 72 Hygiene. I other than the Medical			Manager	other's Name (First, N		Retail		
215-( be filed ntal Hyg rked oth	Be C	17. Father's Name (First, Middle, Last)		atherine F				
2 B & E 5	2	Willie Guest  19a. Informant's Name/Relationship (Type, Print )  19b. Mail	ing Address (Street and				, Zip Code)	
MD nd 2 sho alth and 2 m 27 is raumati			Marquis Dri		Vashing	ton, Mar	y1and 20744 Town State	
Ore, ges 1 a t of He t if ite the ti		1 X Burial 2 Cremation 3 Removal from State crematory or	other place)			•		
altimore, mit. Pages I an epartment of Hea portant: If itee		4 Donation 5 Other Specify: Resurrec 21. Signature of Funeral Service Liouviee. 22	tion <u>Cemeter</u> . Name and Address of Fa	ry //25/2	2008  C	Homes. P	Maryland	
Dept.		Lary & fimmens 5	538 Marlboro	o Pike For	estvil	le, Mary	1and 20747	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	r the mode of dying, such	as cardiac or respira	itory arrest, sh	nock, or heart	Approximate Interval Between Onset and Death	
xaminer	1	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):					Death	
		Sequentially list conditions, b.						
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or Light that initiated						
	Examine	events resulting in death) Last  Due to (or as a consequence of):						
	dical	UNPENDED AMENDED						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	sician/Medio	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ed	ctopic pregnancy	2	3d. Date of deliver	y Day Year	
Sox 687 leath certifi e attending i	iciar	past 12 months?  4 Pregnant at time of death 5	Other (Specify)	otopio progriano,	_ [			
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Di ospital hours a meral	ပ	4 Homicide determined (Specify) Found, Potomac Ri					Washington, MD	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	ledical	one) 2 ✓ Medical Examiner: On the basis of examination and/or invest	curred at the time, date an gation, in my opinion, dea	ath occurred at the tin	ne, date and p	place, and due to the	ne cause(s)	
7 W. W.	Me	and manner stated.  29b. Signature and title of certifier	29c. License nur	mber		d. Date signed (Mo	onth, Day, Year)	
		Carol Hallan	O.C.M.E		Ju	ily 18, 2008		
7		Name and address of person who completed cause of death (Item 23a)     Carol Allan, MD _Assistant.Medical_Examiner 111 Pen	n Street, Baltimore,	MD 21201				
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	reall)					
Regist	rar	JUL 2 3 2008 Been Jo Ag	Con Contraction					

OCME

Physician/ Physician/ Medical Examiner  Nedical Examiner  Nedical Examiner  Physician/ Medical Examiner  As. Facility Name (First, Middle, Last)  Okwambe Malcolm Perry  4a. Facility Name (if not institution, give street and number) Prince George's Hospital Center  Funeral Director  Funeral Director  Funeral Director  Director  As. Social Security Number Social Secu	08-05182 Okwambe Malcoli	m F	Please Type or Print in Black Indelible Ink. Ensure All Corerry  State of Maryland / Department of Health and Menta		egible	е.	
Commonwealth   Comm			1- For State Certificate of Death			201	18 2371
Prince Georges Hospital Center    Finance   Size   Finance   Size   Finance   Size   Finance   F		er	Okwambe Malcolm Perry	Month July 5, 2	008 008		
State   Stat	}±			Death	- 1		
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When the control of t	h the N				Uni		
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29c. License number O.C.M.E.  July 6, 2008  30. Name and address of person who completed caus. If death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed Month, 2018 (22. Registrar's Signature)	P.O.   es that the iigned by the detache	ē	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par		_		
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29c. License number O.C.M.E.  July 6, 2008  30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filled #104th, Qay Year) 108	OD C OD C ending ath. or: Aft	<u></u>	Natural 5 Pending Fpd 7/5/08 upk				
29c. License number O.C.M.E.  July 6, 2008  30. Name and address of person who completed cause if death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filled #104th, Qay Year 1008	Division all or Atturate de la Directe de la	rtifica	3 Suicide 6 X Could not be determined (Specific) apartment	28f. Location or Town	(Street , State)	and Number or F	Rural Route Number, City
29c. License number O.C.M.E.  July 6, 2008  30. Name and address of person who completed caus. If death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed Month, 2018 (22. Registrar's Signature)	the Hospit thin 24 hour the Funers		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place one)	ce, and due to the ca	ause(s) a	nd manner as st	ated.
30. Name and address of person who completed caus of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed 114th, 2a/3 ea/108 132. Registrar's Signature	To wit	ĕ			29d	. Date signed (N	onth, Day, Year)
Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed 1101th, 2017 en 108			( thirtine all		Jul	y 6, 2008	
	Ø			D 21201			
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OCME

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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	_	For State of Ma   = State   = Registrar	aryland	•	artment of H <i>rtificate of L</i>		Mental Hy	giene	2008	23716		
		Hegistrar     Decedent's Name (First, Middle, Last)			rimeate of L		2. Date of De			3. Time of Death		
Physicia /Medica		Kelly Phillips					Tuly	19	2008	1743 PM		
Examine	r	4a. Facility Name (If not institution, give street and number)	00.	1.	4b. City, Town, or	1	,		unty of Death			
Funeral			e (In yrs. las	st birthday)	If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		timore 9. Birthp Cour	place (State or Foreign		
Director		219-96-4109 1☑ M 2☐F Usual Residence of Decedent	37	Yrs.	Months Days	Hours Will.	8/13/1			ngton,DC		
yland		10a. State 10b. County	10c. City,	Town or Lo	ocation		<del></del>		1	0d. Inside City Limits		
Ba-fsl	Director	Maryland Prince George's	Temp	1e H:						1x Yes 2 No		
with the		10e. Street and Number			10f. Zip Code 20748	0		•	of What Cour d State			
death	Funeral	4302 Lyons Street  11. Marital Status  12. Was Decedent E Armed Forces?	Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No		Race - Americ Black, White,	can Indian,		
ours after death with the Marylan ral", or items 23a or 28a-f show	by Fu	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ N	No		1 ☐ Yes 2 🛣 No	Specify:	o mean, etc.	1	pecify: Bla	1		
10a. State   10b. County   10c. City, Town or Location										dustry		
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filed w Hygie other ti	<u>ဂ</u> ြ	12 17. Father's Name (First, Middle, Last)		Mail	Handler	18. Mother's Nan				Services		
Specify   Spec												
2 sho and I is ma rauma		19a. Informant's Name/Relationship (Type. Print)			ng Address (Street a							
1 and Health em 27	ŀ	Gwendolyn D. Phillips / Mot 20a. Method of Disposition	ther 20b. Pla	ce of Dispo	Lyons Sti	1	ole Hill		ryland tion - City or To			
Pages nent of nt: If ii		1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cer	netery, cre	matory or other place memorial	i	5/2008	Lando	war Ma	rvland		
permit. Departn Importa any inju		21. Signature of Funeral Service Licensee	патп	2	Name and Addres	ss of Facility Poj	pe Funer	al Ho	mes, P.	A.		
0.0 = # 0	_	232 Part 1 Enter the decase or complications that caused	I the death		538 Mar1bo				Maryla	and 20747 Approximate		
Physician		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir Immediate Cause (Final	ne.	50110101	A O Cal	u l $\lambda$	ea 10	iriost,		Interval Between Onset and Death		
/Medical	disease or condition resulting in death)  a											
Examiner	7	Sequentially list conditions,	a conseque	nce of):								
executed n and al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. OA V	dic	Awest	-						
o	_	resulting in death) Last Due to (or as	a conseque	ence of):								
The law requires that the death certificate by ate has been signed by the attending physici bage 2 should be detached for use as the bu	Physician/Medica	d										
th certition and the certition of the ce	an/Me	IF FEMALE: 23b. Was decedent pregnant in the post 10 months?  23c. If yes, outcome 1 □ Live birth			☐ Ectopic pregnanc	v		230	d. Date of deliv			
ne deat the att hed for	/sicia	in the past 12 months?  1 Yes 2 No 9 Unknown			Other (specify)	у			Month	Day Year		
that the that the second secon		Part II. Other significant conditions contributing to death be	ut not result	ting in the u	underlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to t	the cause of death?		
equires en sign	ed by						1 🗆	Yes 2	No 3□ Pro	bably 4 Unknown		
has be	Completed						24a. Was	psy	prior to co	opsy findings available ompletion of cause of		
in: The ificate or, pag	e Co	25. Was case referred to medical				00 Blass of Do	1 □Yes	$\wedge$	death? 1 ☐ Yes	2 □No		
Physician: this certifica	To Be	examiner?	ent 2 🗆 E	R/Outpatie	ent 3 DOA Oth	26. Place of Deler: 4 ☐ Nursing F	atn ( <i>Cneck only</i> Home 5 ☐ Res		☐Other (Spec	ify)		
ding Physician: The I h. After this certificate he funeral director, page		27. Manner of Death 1 Natural 5 Pending (Month, Da		28b. Time o Injury	Worl		28d. Describe	how injury o	occurred			
Attend death ctor: ,	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury	ury - At hon	ne, farm, st		Yes 2 □No	28f. Location	(Street and I	Number or Rui	ral Route Number,		
27. Manper of Death 1 M Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 1 I Yes 2 No 28c. Injury at Work? 1 I Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurr												
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3		30. Name and address of person who completed cause of d	death (Item)	23a) (Type	, Print)	651		2	4 17	2008		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 7-21-2008 5:45AM Eleanor J. Peterson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Balto. Oakcrest Village Retirement Center Parkville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🛛 F Director 7-13-1923 New Jersey 138-18-8821 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 7-21-08(0542 1 ☐ Yes 2 No Balto. Parkville Director Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8800 Walther Blvd. 21234 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 27 No Specify: White Completed by 3√2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th <u>Bookkeeper</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Jones Walter Bowers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BelAir ,Md 21015 1403 Lytham Ct. Ron Peterson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Highview 7-24-2008 **Fallston** 21. Signature of Funeral Service sicensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 Tous Buen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): Alzheimer's /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physiclan/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I δ 21-1 No 1 ☐ Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ filled in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Walther Blud Parkville, MD 21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

MD 8800 1932. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (Ff3t, Middle, Last) **Physician** 9:10 A M 20, 2008 eer 4b. City, Town, or Location of Death /Medical 4c. County of Deat 4a. Fecility Name (If not institution, give street and number Examiner ueenstown Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 7. Age (In yrs. last birthday)
90 Yrs. 1 Year Days Number 6. Sex **Funeral** Hours Months 220-36-9393 1 □ M 2 💢 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State Items 23a or 28a-f show other treumatic event, the Medical Examiner niust but utilitied at 1 Yes 2 No Anne MD Be Completed by Funeral Director Hrunde evern 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21144 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 5 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify: Black 3 Widowed 4 □ Divorced "neturel" 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nt of Health and Mental Hygiene.

If item 27 Is marked other then or other treumatic event, the Me ecoddary (0-12) College (1-4or 5+) omestic Middle, 18. Mother's Name (First, Middle, Maiden, Suman Father's Name (First, olson toward Hines 9a. Informant's Name/Relationship (Type 1538 Hickory Wood Dr. 1 Burial 2 □ Cremation 3 Removal from State Department of Importent: If eny injury or once. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Pilce Balto. N 23a. Part1. Enter the clease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UYNS ALZHEIMERS Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner Division of Vital Records, P.O. Box 687605. use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 Sesidence 6 ☐ Other (Specify) 1 Yes 2 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After the 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Zeath 1 ANatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funerel Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 02783 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

SIMON

**ORIGINAL** 

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 7:35 A M JULY 2008 **THOMAS** RANDALL, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRICE GEORGE'S MARYLAND HOSPITAL CENTER CLINTON SOUTHERN If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Securify Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. t**▼** M 2□ 4/30/1941 Washington, DC Director 67 579-54-2999 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other thaumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at Yes 2 □ No Director Maryland Prince George's Temple Hills 10g. Citizen of What Country? 10e. Street and Number 20748 United States 4004 Leisure Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or ite 1 Yes 2 No If Yes, Give Year or Dates; 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fannie Mae Mortgage Co. 12 Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maitland Louise Gordon Burl Thomas Randall Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 4004 Leisure Drive Temple Hills, Maryland 20748 Queenie Walls- Randall / Wife Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crem. 7/19/08 4 □ Donation 5 □ Other (Specify) Alexandria, VA 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licens 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part1. Erner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director: After this certificate h completely filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Tes 2No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 ☐ Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of DO053219 30. Name and address of person who completed cause of death (Item 23a) (Type\_Print)

State Registrar

DHMH 17 Rev 1/2001

MD ( Registrar's Signature POST Office Road Walder

08-05477 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 23720 State of Maryland / Department of Health and Mental Hygiene John Buford Rose 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day July 17, 2008 0504 hrs Medical Examiner FORD 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard Howard County General Columbia 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Davs Hours Min. Director Country) 15-98-9322 1 V M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 1 Yes 2 No 28a-f show the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Numbe 21044 1.5. items 23a or Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Ouban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, Black, 11. Marital Status Was Decedent Ever in U.S. 1 Never Married 2 Married mit. Pages I and 2 should be filed within 72 hours after dear artment of Health and Mental Hygiene. Triant. If frem 27 is marked out. 9 Yes, Give Year 1981 Specify: WhITE Yes 2 \ No specify: Divorced Widowed 4 à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) SOLDIER 18.Mother's Name (First, Middle, Maiden Surnan 17. Father's Name (First, Middle, Last) STORD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print.) JORD RO Baltimore, MD MOI LANSING RD. GENBURNIEMD, 21060 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Department of Important: I injury or oth 7-19-08 REMATORY HANDVER. Donation 5 Other Specify 22. Name and Address of Pacility DAUGNERTY FAMILY FUNERAL HOME 21. Signature of uneral Service Lious 2601 MOUNTAIN RD. PASADENA, MD. 21122 Approximate Interval at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or complications Physician Between Onset and failure. List only one cause on ea Medical Death Complications of quadriplegia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): cervical spinal cord injury Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine blunt force trauma of the neck cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transi Physician/Medical AMENDED PI line a-c,27,28a-f,perME, g882 8/12/08 TT X UNPENDED attending physician or use as the burial death certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IE EEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months' Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown detached for g 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. \$ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an has been prior to completion of cause of autopsy s certificate has rector, page 2 sl performed? death? ✔ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) Fo the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be examiner? Other Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 DOA this ဥ 1 V Yes 28a, Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death subject injured neck diving Certification: 1 Natural Yes 2X No Pending 24 hours after death. Funeral Director: tely filled in by the unk into a pool 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined (Specify) unk Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the F Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

Registra

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Russell Alexander MD

and manner stated

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

July 17, 2008

**COMP** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND III #200, perith, 0801, 1/2 / 08, WS

State of Maryland / Department of Health and Mental Hygien 0 0 8

AMEND III #22, perith, 0821, 1/16 are W Death

Reg. No. 1 - For State Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Mildred Reed 7:07 AM July 16, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Future Care Canton Harbor Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☒ F 212-26-1759 Nov 13, Director 1916 Virginia Usual Residence of Decedent with the Maryland \*how 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or items 23a or 28a-f showing the Wedical Examiner wast be notified at MD N Y☐Yes 2☐No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1300 S. Ellwood Avenue 21224 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ent of Heatth and Mertal Hygiene. ont if item 27 is marked other then "natural, or ite may or other treumatic event, the Murical Excuring Iny or other treumatic event, the Murical Excuring 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: black ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leroy Scott Zaida Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Reed/daughter 5535 Hutton Avenue Woodlawn, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 25 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Importent: If eny injury or once. 4 Donation 5 Doner (Specify) in state MT.ZION CEMETERY July 24,2008 BALTIMORE, MD. 22 Name and Address of Facility Calvin B. Scruges Funeral Hore
State and Address of Facility B. Scruges Funeral Hore
Rall imore, MD 21201 21. Signatur, funeral ryice Licensee Wade, Mirector Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician coson arten divine /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner P.O. Box 68760, 56 requires that the death certificate be executed burial-transit Due to (or as a consequence of): Physiclan/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 No detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð Stage spunt dissere 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 Yes 2 No 2 No To the Hospitel or Att. nding Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of contified 2008 DUOL 5249

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State Registrar St. Paul Place

301

32. Registrar's Signature

Baltimer, in D

21202

Site Eur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Davidson MD

31. Date filed (Month, Day, Year)

<b>Physician</b>	
/Medical	
Examiner	

**Funeral** Director works

"natural", or items 23a or 28a-f sho idical Examiner must be notified at traumatic event, the Medical permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygic Important: If item 27 Is marked other i any Injury or other traumatic event, tt

72 hours after

Maryland 21215-0036

Baltimore,

Box 68760.

P.0.

**Physician** /Medical **Examiner** 

that the death certificate be executed and burial-tra physician as attending use ģ signed t page 2 certificate | Hospital or Attending Physician: 24 hours after death. After the Funeral Director: #

Division or Vital Records, Certification: Medical the State Registrar

29b. Signature and title of certifier

Dona Leekuski

31. Date filed (Month, Day, Year)

JUL 0 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9200 Basil Ct. Largo,

32. Registrar's Signatur

1. Decedent's Name (First, Middle, Last) <sup>Day</sup>2008 George H. Slye June 30, 7:05 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4202 - 58th Avenue #323 Bladensburg Prince George's 8. Date of Birth (Month, Day, Ye Oct. 18, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Year) 933 Days Hours 1☐M 2□ F Washington, DC 579-48-3428 74 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits YZYes 2 □ No Director Maryland | Prince George's Bladensburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4202 - 58th Avenue #323 20710 United States Funera . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. African 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【No Specify Specify: American ੬ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Government Elementary/Secondary (0-12) College (1-4or 5+) yéars Painter (DC Public Schools) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Slye Clouie Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4202 - 58th Ave. #323 Bladensburg, MD 20710 Catherine E. Slye - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4. □Donation 5 □ Other (Specify) July 12, 2008 Landover, MD Harmony Mem. Park 22. Name and Address of Facility Stewart Funeral Home, Inc. nature of Funeral Service Livence 21. Si 4001 Benning Road, NE Washington, DC 20019 23a. Part Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Malignant Neoplasm; other specied sites of Pancreas Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes £ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Avatural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29c. License number

DHMH 17 Rev 1/2001

MD 20774

1466665

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mar	yland / Depa <i>Ce</i>	artment of I <i>rtificate of</i>	Health and M <i>Death</i>	ental Hygid Red	ene 2008	23723
	Physic		1. Decedent's Name (First, Middle, L Donna Selway	,				2. Date of Death Month 7-15-20	Day Year	3. Time of Death 3:45a M
Edge.	/Medi Exami		4a. Facility Name (If not institution, g. 2414 Hunter M	ive street and number)			or Location of Death	, 13 10	4c. County of Death	h
	Funeral Director		219-44-6884	1 DM 2 TE	In yrs. last birthday) 2 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, 8-24-194.	(ear) 9. Birti Cou	hplace (State or Foreign untry) ID •
	//aryland f show	or	Usual Residence of Decedent  10a. State  10b. County		Oc. City, Town or Lo					10d. Inside City Limits 1 □ Yes 2 □ No
	h with the h 23a or 28a- st be notifi	al Director	MD Balto 10e. Street and Number 2414 Hunter M			White H		100	g. Citizen of What Cou	untry?
960	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Exercitival to a natified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of h fYes, specify Cub I □Yes 2M No	Hispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
Maryland 21215-0036	filed within 72 ho Hygiene. other than "natul ent, the Medical	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) 12	ducation rade completed) College (1-4or 5+) Masters	(Give life. L	dent's Usual Occup kind of work done DO NOT use retire eacher	pation during most of worki d)	ng	bb. Kind of Business/li	of Balto.
yland	should be filed wand Mental Hygies marked other taumatic event, to	To Be (	17. Father's Name (First, Middle, Las Albert Marlowe	t)				T. Dauber	r	
e, Mar	s 1 and 2 sho of Health and item 27 is ma other trauma	ĺ	19a. Informant's Name/Relationship  James P. Selwa	y ,Jr. Husba	ind 2414	Hunter	Mill Rd.	White Hal	City or Town, State, Zi	61
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition  1 □ Burial ★□ Cremation 3 □  4 □ Donation 5 □ Other (Speci	Removal from State	Bayview 22	natory or other place.  Name and Addre	7-16-	2008 1 Schimune	c.Location-City or T Balto. Cit ek Funeral	y Home
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, to ay leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	pplications that caused the rone cause on each line.  a.  Due to (or as a co	onsequence of):	7.20 A	ng, such as cardiac c	or respiratory arrest	n, Md.2123	Approximate Interval Between Interval Between Inset and Death
O. Box 68760,	ne death certificate be execute the attending physician and hed for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p  1	regnancy	Ectopic pregnanc	у		23d. Date of deliv	very Day Year
ords, P.	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions	contributing to death but no	ot resulting in the un	derlying cause giv	en in Part I.		cco use contribute to t	the cause of death?
ital Rec	lan: The law rtificate has b tor, page 2 st	Be Completed	25. Was case referred to medical				26. Place of Death	24a. Was an autopsy performed 1 Ves 2	prior to co d? death?	opsy findings available ompletion of cause of 2 17No
Division of Vital Records,	In the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a completely filled in by the funeral director, page 2 should be detached for use a completely filled in by the funeral director.	Certification: To E	examiner?  1 Yes 2 No  27. Manper of Death  1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day, Ye	At home, farm, stre	28c. Injur Work M 1 🗆	er: 4 Nursing Hon y at 2 Yes 2 No	ne 5 N Residence 8d. Describe how	and Number or Run	
Δ .	Hospital or 24 hours afte Funeral Dir etely filled in	edical Cer	29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Exar	nysician: To the best of my niner: On the basis of exa and manner stated.	y knowledge, death imination and/or inv	occurred at the tir estigation, in my o	me, date and place, a pinion, death occurre	and due to the caus	se(s) and manner as	stated. o the cause(s)
)	Nithin 24 hor To the Fun To the Fun Completely	Σ	29b. Signature and title of certifier  30. Name and address of person who	ur 1	(Item 232) (Time B		e number 33624	29d.	Date signed (Month,	Day, Year)
į	Sta Registra	te	Dr. J. Down 31. Date filed (Nonth, Day, Year)	7505 Osler I	or. Towso	,	204			
אורוע	ID 17 Rev 1/20	רטו	JUL 2 3 2008	process di	Good	Table 1				-

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 30 per dvr, g881,07/23/08/bb Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1455 8002 ana /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westurington

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Hours | Min. | (Month, Day, Year) Carro Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday, 5. Social Security Number **Funeral** 1 x M 2 □ F 217-24-2766 76 PA Director Aug Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Finksburg 1 ☐ Yes 2 📆 No MD Carrol1 Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21048 2803 Matthew Drive Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: þ white 3 X Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) packaging salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kathleen O'Connor Franklin Joseph Sturtz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1511 Knox Dr., Westminster, MD 21157 David Sturtz (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Marriottsville, MD Crest Lawn Memorial 7-21-08 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Daige Haight Oferbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** Ke r as a consequenc of): /Medical Due t Examiner Meumonta Sequentially list conditions, if any teconic to in modalic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by a page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Completed by 3 Probably 4 □Unknown 2□ No 1 Yes 24b. Were autopsy findings available 24a. Was an certificate has performe death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Tes 2 No 2 ER/Outpatient 3 DOA Certification: To Director: After this 27. Mann To Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 5 ☐ Pending in vestigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month. Dav. Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

State Registrar Konn

3 2008

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31. Date filed (Month, Day, Year)

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2008 Juli Sknarin F. Yuriy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Himore altmore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 1⊠M 2□ F Yrs. May 15. Russia Director 212-61-1007 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2x No Director Reisterstown Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21136 Russia 38 Ridge Lawn Road other traumatic event, the Medical Examiner must Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items, 11. Marital Status 1 ∐Yes 2 TxNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify \$ 3 ☐ Widowed 4 ☑ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Mishe's Home Impr. 12 Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown ۵ Fyodor Sknarin Known 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S Health tem 27 i 9014 Groff Mill Drive Owings Mills, MD 21117 Daughter Mariya Sknarin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser 7/21/08 Hampstead, MD Patient 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Reisterstown, MD 21136 ELINE FUNERAL HOME Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician dacyenitaitis /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Due to or as a consequence of). Division of Vital Records, P.O. Box 68760, physician Completed by Physician/Medical the the attending posterior IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year signed by the a 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ ¥0 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 □ Yes 2 □ No 2 MNo 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D68810 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

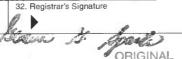
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State 31. Date filed (Month, Day, Year)
Registrar

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State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	Olato	or mary	Ce	rtificate of	Death		Reg. No. 2	8 U	23/26		
	Physici	an	1. Decedent's Name (First, Midd						July 19		Year	3. Time of Death		
· Alice	/Medic	al	Karen Anne S  4a. Facility Name (If not institution		numbar)		4h City Town o	r Location of Death		4c. County o	of Death	12:50A M		
	Examin	er	Gilchrist Ho	-			Towso			Baltin				
	Funeral Director		5. Social Security Number 219.82.4314	6. Sex		yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day May 31,	1963 V	Cour	place (State or Foreign ntry) ington D.C.		
	and		Usual Residence of Decedent 10a, State 10b. County	,	10c	. City, Town or Lo	cation				1	10d. Inside City Limits		
	Maryl.	tor	Md Howa	ırd	I	Laurel						1 ☐Yes 2 No		
	or 288	Direc	10e. Street and Number				10f. Zip Code			10g. Citizen of W	hat Cour	ntry?		
	s 23a	Funeral Director	11312 Castlewo		ecedent Ever i	-116 110	20723	diamenia Origina (C	nacify Van or Na	USA	Amoria	can Indian,		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evanimat must be reatilized at once.	ρ	11. Marital Status  1 □ Never Married 2 X Mar  3 □ Widowed 4 □ Divorced	rried Armed	Forces? Size No Give Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 XNo		o Rican, etc.)	Specify:	, White,	etc.		
15-0	"natul	letec	15. Deceder (Specify only highe	nt's Education est grade complete	ed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	oation during most of wor	king	16b. Kind of Bus	iness/In	dustry		
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nd 2	e filed al Hyg I other	Be Completed	17. Father's Name (First, Middle,							Maiden Surname	;)			
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Mai	nd 2 sh alth and 27 is n r traun		19a. Informant's Name/Relation: Frank Lee Smith	ship ( <i>Type. Print)</i> 1- Husbar	ıd	1131	ng Address (Street 2 Castlev	wood Ct.	Laurel,	Md 20723	3	o Code)		
Baltimore, Maryland 21215-0036	ges 1 a t of Hea If Item or othe		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation	3 ☐ Removal fr	om State		matory or other pla		Date	20c. Location - 0	,			
Ei m	it. Pag irtmen irtant: njury		4 Donation 5 Dother (5	Specify)	Me		ge Mem Pa					1 Hm atMMP		
Ba	perm Depa Impo any i		21. Signature of Funeral Service	I ma	- MOIC		250 Washi							
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications th	at caused the con each line.	leath. Do not er	ter the mode of dyi	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between		
ч	Physician		Immediate Cause (Final disease or condition resulting in death)	•		al/ce/1	lung	Cancer				Mouths		
4	/Medical Examiner		resulting in death/	Due	to (or as a con	sequence of):	,							
ĺ	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
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68760,	te be e ysiciar ie buria			d										
		Medical	IF FEMALE:											
Вох	eath cer attendir for use	Physician/	23b. Was decedent pregnant in the past 12 months?	1 🗆 L	outcome of pro ive birth 2 regnant at time	Fetal death 3	☐ Ectopic pregnand	су		23d. Date Mor		very Day Year		
P.O.	at the de by the stached	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		Inknown									
S, F	es that igned I be det	by	Part II. Other significant condit	ions contributing	o death but not	resulting in the u	ınderlying cause giv	ven in Part I.		obacco use contri Yes 2 □ No		the cause of death?		
Soro	v require been signature	eted							24a. Was					
Rec	he law te has age 2 s	Completed							autor perfo	rmęd? d	leath?	opsy findings available ompletion of cause of		
ta	Physician: The lav this certificate has al director, page 2 a	Be C	25. Was case referred to medica examiner?	al				26. Place of Dea	1 □Yes ath (Check only o			2 140		
of V	Physic this ceral dire		1 Yes 2 No			2 ER/Outpatie		4 🗆 Nursing r		dence 6 20the	. ,	in Hospice		
on (	ding F. h. After funera	tion:	27. Manner of Death 1 Matural 5 ☐ Pendi 2 ☐ Accident invest	ng (/	ate of Injury Month, Day, Yea	28b. Time ( Injury	Wor	ryat rk? ]Yes 2∐No	28d. Describe	how injury occurre	)G			
Division of Vital Records,	l or Attend after death Director: /	Certification: To	3 ☐ Suicide 6 ☐ Could	not be 28e. P	ace of Injury - A	 At home, farm, st <i>pecify</i> )	reet, factory, office		28f. Location (3 City or Tox	Street and Number	er or Rur	ral Route Number,		
	Hospital or Attending Physician: The law requires that the death ce 24 hours after death. Funeral Director: After this certificate has been signed by the attenditely filled in by the funeral director, page 2 should be detached for use	I Cer	29a. Certifier 1 Certify	ing Physician: To	the hest of my	knowledge dea	th occurred at the t	ime, date and plac	e, and due to the	cause(s) and ma	nner as	stated.		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only one)	I Examiner: On the	ne basis of examenanner stated.	mination and/or i	nvestigation, in my	opinion, death occ	urred at the time,	date and place, a	and due t	to the cause(s)		
	To the I within 2 To the I complete	Σ	29b. Signature and title of certific	er 2/0	10.0		29c. Licen:	6 ( 9 9		29d. Date signed		LOOS		
	5		30. Name and address of person	who completed	cause of death	(Item 23a) (Tvne	Print)	011 (7		34141	. /	0000		
	2)		Jason Black	. 656	5 Not	The Char	iles st	suite 2	09. ToL	son Ul.	١ .	21204		
	Sta Registr		31. Date filed (Month, Day, Year		2 Registrar's S		a. 6. 0	25				**		
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page 2 should death. after death the within 24 hours after dear To the Funeral Directo completely filled in by the

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Completed

Be

Certification: To

Medical

Records,

Division of Vital

26. Place of Death (Check only one)

35046

24a Was an autopsy performed? res 2 No 1 □Yes 1 Tyes

2 🗌 No

23e. Did tobacco use contribute to the cause of death?

24b. Were autopsy findings available prior to completion of cause of death? 2 No

3 Probably 4 ☐ Unknown

25. Was case referred to medical 1 ☐ Yes 2 XNo 27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

5 Pending investigation

determined

28a. Date of Injury (Month, Day, Year) 6 Could not be

Hospital:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

and manner stated

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 28c. Injury at Work? 1 ☐Yes 2 ☐ No

5 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

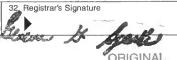
29c. License number MDO 29d. Date signed (Month, Day, Year)

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aiwu Ruth He, MD, 3800 Reservoir Rd, NW, Washington, DC 20007

31. Date filed (Month, Day, Year) State Registrar



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 29<sup>Day</sup> Decedent's Name (First, Middle, Last) **Physician** 2008 June 9:55 AM Richard Joel Schneider /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Columbia Howard Howard County General Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X**1M 2□ F New York 125-34-5298 63 July 25,1944 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State 1 ☐ Yes 2 No Director Maryland Howard Fulton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20759 U.S.A. 12289 Scaggsville Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify þ White 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Neurophysiologi</u>st Medical Research 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Helterman Albert Schneider ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9324 North 110th Street Scottsdale, AZ 85259 Lynn Neuville (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State Catonsville, MD 7-2-2008 4 □ Donation 5 □ Other (Specify) Metro Crematory 22. Name and Address of Facility
Witzke Funeral Homes, Inc.
5555 Twin Knolls Road Columbia, MD 21045 21. Signature of Funeral Service License 23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Just only one cause on each line. Immediate Cause (Final Physician End Stage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Brand Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Leuco Cyto Physician/Medical IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 1 | Yes 2 | No 3 | Probably 4 Donknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 🗌 Yes 2∏No 1□ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2√20No Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

4 THomicide

(Check only

29a. Certifier

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

9650 Santrejold Suite 110

ND 21045

17

Registrar

Medical

31. Date filed (Month, Day, Year)

52. Registrar's Signature

reple MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			. For	State	of Mar	yland	/ Depa	rtmen	of H	ealth a	and M	ental Hy	giene			_
		1	State Registrar				Cer	tificate	e of D	eath		2. Date of Dea	Reg. No. 2	008	3 Time of Death	9
	Physicia		1. Decedent's Name (First, Mid-	dle, Last)				STO	YENE	(0		Month JULY		200 <sup>Year</sup>	6:30A	М
	/Medic	-	4a. Facility Name (If not institut	ion, give street and	f number)					Location of	of Death		4c. Co	unty of Death		
	Examine	er	KESWICK MUL						ALTIN						/A	ian
	Funeral		5. Social Security Number	6. Sex 1 <b>X</b> M 2 □	7. Age	(In yrs. la	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birl (Month, Da 01/31/	1927	9. Birth	place (State or Fore htry) MD	igii
	Director		219-22-8540 Usual Residence of Decedent			81						01, 01,			I0d. Inside City Lim	ita
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e .	f Heal	-	20a. Method of Disposition			20b. Pl	lace of Disp emetery, cre					Date	20c. Loca	ation - City or	Town, State	
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ш	On Part Flater the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest												arrest,		Approximate Interval Between	n
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	hysician /Medical		disease or condition resulting in death)	a	ue to (or as		-									
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99	ertifica ing ph e as th	Completed by Physician/Medi	IF FEMALE:	220 16 14	es, outcome	of pregna	ancv						2	3d. Date of de	livery	
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o l	the de y the	ysic	1 □Yes 2 □ No 9 □ Unknown	9 🗆	] Unknown							lles Bi		ee eentributo t	o the cause of deat	h?
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Sec	e 2 sh	nple		> MY O / 4	Thy							au pe	topsy rformed?	prior to death?	completion of caus	e of
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o c	fter thi	lino	27. Manner of Death  1. Natural 5 □ Pe		. Date of Inju (Month, Da	ury ay, Year)	28b. Time Injur		28c. Inj	ury at ork? ⊒Yes 2	□No	28d. Describ	e how injur	y occurred		
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		tate	31. Date filed (Month, Day,	Year)	32. Regis	trar's Sigr	nature	Joans								
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DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Frances A. Strauss 12:50 PM Jul 19, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard 6336 Cedar Lane If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 X 141-05-1673 89 NJ Director Jul 14, 1919 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Howard Columbia 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 6336 Cedar Lane 21045 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ∰ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: þ Specify: White 3₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tracer Trucking 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Samuel Aron Sarah Gross 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Jesse Strauss Son 26 Devonshire Terrace West Orange, NJ 07052 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 Removal from State Jul 23, 2008 Woodbridge, NJ **Beth Israel Cemetery** 21. Schalture of Furteral 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** o Minutes /Medical Due to (or as a consequence of **Examiner** Scientially III on III or if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 🗌 No 3 ☐ Probably 4 ☑ nknown 1 Tes page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No this certificate has autopsy performed? Yes 2 (No 1∏ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 5 Residence 6 □Other (Specify) funeral 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division or Vital Records, P.O. Box 68760, hin 24 hours after death the Funeral Director: filled in by the Hospital ပ

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State Registrar

egistrar's Signatur 31. Date filed (Month, Day, JUL 23 2008

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Medical

29b. Signature and title of certifier

30. Name and address of person who

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 23731 Certificate of Death Rea. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 07-11-2008 20:49 P<sup>M</sup> William Henry Tipton, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore VA Medical Center Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 01-01-1922 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours Country) Virginia XXM 2 DF 86 Director 226-18-3923 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Experience must be notified at 1 ☐ Yes 2 No Director MD Wicomoco Mardela Springs 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11386 Sandomingo Road 21837 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 ⊠Yes 2 ☐ If Yes, Give Year or Dates: 2 ☐ No 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 □Yes 2 🛛 No Specify. Specify: Ş Army White 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Bar 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Floyd Tipton Ruby Constance Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie D. Tipton-daughter 2437 Westport St., Baltimore, Maryland 21230 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation / □ Other (Specify) 14, 2008 Meadowridge Mem. Pk. Elkridge, MD 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service Licen. M00053 MMP, Inc., 7250 wash. Blvd., Elkridge, MD 21075 23a. Part 1. Er er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C, use (Final disease or c indition resulting in death) Physician Metastatic Lung Cancer /Medical Due to (or as a consequence of): Examiner Possible Pulmonary Embolus Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se's consequence of) Examiner burial-transi and Due to (or as a consequence of): Box 68760, attending physician for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown 5 Other (specify) P.O. the 9 Unknown s been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy certificate 2KNo 1 ☐ Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 2X No 1 Nnpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes Certification: To this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? After or Attending 5 Pending investigation 1X Natural after death. 1 ☐ Yes 2 ☐ No М 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WP 2+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aimee Bennis, 10 North Greene St., Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 3 2008 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2008 Physician July 19, 9:42 AM M Edward R. Valencia /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 09/24/1935 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. MD Country) 1 34 M 2 □ F 72 578-52-0959 Director Usual Residence of Decedent 10a, State 10b. County 10c. City Town or Location 10d. Inside City Limits Director 1 □Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8812 Sundale Drive 20910-Phillipines Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 2 1 ☐ Yes 2 No Specify: Specify: Caucasian 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Automotive Elementary/Secondary (0-12) College (1-4or 5+) Business Owner 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abelardo Luna Valencia Socorro del Rosario ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 Is
any Injury or other trau Debra Valencia/Daughter 4419 Crest Drive, Manhattan Beach, CA 90266-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jul 22 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State Beltsville, Maryland 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cerebrivescular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy In the past 12 months? Month Year Pregnant at time of death 5 Other (specify) I □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☑ Unknown Kespirectory 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an oneumoni autopsy 2 No hupertension Diabetes 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was e referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient P 2 ER/Outpatient 3 DOA

Examiner The law requires that the death certificate be executed bunal-transit P.O. Box 68760, signed by the attending physician I be detached for use as the buria Division of Vital Records, has been page 2 certificate the Hospital or Attending Physician: director, funeral After death. Director: filled in by the after To the Hospital within 24 hours a To the Funeral E

with the Maryland

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be retified at

Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
wit: If item 27 Is marked other than "natural", or items 23a mit: If item 20 items 20 items 20 items 20 items 20 items 20 items 10 item

Baltimore, Maryland 21215-0036

27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062167 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

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State Registrar

DHMH 17 Rev 1/200

31. Date filed (Month, Day,



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7-20-08

State of Maryland / Department of Health and Mental Hygiene 2008 23733 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Jack Donald Venable, Sr. July 19, 2008 1:20 p.<sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Days Hours Min. Birthplace (State or Foreign Country)
 New Mexico 5. Social Security Number 8. Date of Birth (Month, Day, Ye June 12, 6. Sex 7. Age (In yrs. last birthday, Year) 1926 **Funeral** Days Hours 1 ₹ M 2 □ F 525-36-5646 82 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2 ☐ No MD. Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1106 Mainsail Drive 21403 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 X Yes 2 No Korch If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Naval Officer U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental I Offie Leon Venable Blanche Ferguson ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 & Department of Health ar Important: If item 27 Is any Injury or other trauonce. 5929 Deale Beach Rd. Deale, Maryland 20751 Leslie Williams (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Chesapeake Crematory, Inc. Beltsville, Maryland 4 □ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Philip D. Rivalci Fureral Service, P.A. 9241 Columbia Blvd. Silver Spring, Maryland 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): NONISCHEMIC CARDIOMY OPARMY Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-trai Division or Vital Records, P.O. Box 68760. Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò ATLURE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate spital or Attending Physician: The hours after death.
Ineral Director: After this certificate by filled in by the funeral director, par 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifiq 29d. Date signed (Month, Day, Year) N4/4/7 12008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15

Registrar DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9:35 PM **Physician** . Month 2008 4a. Facility Name (If not institution, give street and number July /Medical 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Rehabilitation Baltimore N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)
71 Yrs. If Under 1 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** Days Hours 081-26-2139 1 X M 2 □ F VA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic page. 10a. State 10c, City, Town or Location 10d. Inside City Limits MD N/A XXYes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 McMechen Street Apt. 208 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. Š Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Maintance American Techology 12th N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Curtis ပ Wyatt Florence Bonner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Apt. Baulah Wyatt-wife 301 McMechen Street Baltimore, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville Va 7/28/08 Crownsville 4 Donation 5 Dother (Specify) MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST H la Warre 1101 E. North Avenue Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ocellular Physician Hepat Laveinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ivision or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 1□ Yes 2 1 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury 1 □ Yes 2 □ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier 29d. Date signed (Month, Day, Year) ile III MD 2008 42 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
Loch Raven Bonlevard Battimore, reovae E.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Exam		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, o	r Location of Death	4	c. County of Death	
-s*		5. Social Security Number 6. Sex	7. Kge (In yrs. last i	birthday) If Under Year	If Under 24 Hrs.	9 Date of Birth	15917 ina	ce (State or Foreign
Funera Directo			M 223F 58	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea, April 9,	1950 Maryla	and
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J36 irs afte	by F	1 ☐ Never Married 2 🙀 Married 3 ☐ Widowed 4 ☐ Divorced	1	1 ☐ Yes 2 <b>X</b> No	Specify:		Specify: Whi	te
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ZTZT; I within 7 giene. r than "r	Completed	(Specify only highest grade	0-11 (4.45.)	(Give kind of work done life. DO NOT use retired Service Admin	auring most of workii d) istrator	ng T	elephone	
		17. Father's Name (First, Middle, Last)		ervice numin		(First, Middle, Maide		
	To Be	Louis Martin Hamil	ton. Sr.			Mary Bros	•	
larylan 2 should be and Menta is marked aumatic ev	F	19a. Informant's Name/Relationship (Type		9b. Mailing Address (Street	<del>_</del>		· · ·	ode)
		Jim Williams		904 Calais C		dsor Mill,	MD 21244	
Daltimore, permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Re	emoval from State 20b. Place ceme	e of Disposition (Name of etery, crematory or other plac			Location - City or Town	, State
ITIITI iit. Pa artmer artmer injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		Cathedral Cem	7/25/		ltimore, Ma on Schwab	
Dalt permit. Departn Importa any Inju	NIK	21. Signature of Furieral Service occurse	L'Menda	Funeral H	ome of Car	tonsville,	Inc. sville, MD	21228
		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. D					pproximate terval Between
Physician		Immediate Cause (Final disease or condition	Resolute A	f 1150			Ö	nset and Death
/Medica Examine		resulting in death)	Due to or as a conseque v	e of):				
W		Sequentially list conditions, b.	Due to jor as a consequence	e of Teg	cophec.		7822910	
cuted Id	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	(h+26)0 0	be true 1	ps/m.	andia	-2	
e exection and an arrial-tr	Exa	resulting in death) Last	Due to (or as a consequence	e of):	1	ory		
ficate be (	edical	d.						
certifii ding p	/Me	IF FEMALE:	Bc. If yes, outcome of pregnancy				Ond Data of delisions	
death ce attendii	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		у		23d. Date of delivery  Month Da	ay Year
by the	hys	9 Unknown	9 ☐ Unknown					
res the signed be de	þ	Part II. Other significant conditions conf	ributing to death but not resulting	g in the underlying cause giv	en in Part I.	11	use contribute to the c	
law requires t as been signo 2 should be	Completed					1 □ Yes	No 3□ Probabl	ly 4 ☐ Unknown
ne law e has b	lg m					24a. Was an autopsy performed?	24b. Were autopsy prior to comple death?	y findings available letion of cause of
an: The tificate or, pa	ပိ	25. Was case referred to medical			26 Place of Death	1 □ Yes 2	lo 1 ☐ Yes 2 [	□No
ysicia is cer direct	To B	examiner?	ospital: 1 ☑ Inpatient 2 ☐ ER/0	Outpatient 3 DOA Oth	26. Place of Death er: 4 ☐ Nursing Hor		6 ☐ Other (Specify)	
ng Ph After th	L:no	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year) 28b	o. Time of 28c. Injury Worl		28d. Describe how inju		
Seath. Seath. Tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be		M 1 🗆	Yes 2□No			
lor At after of Direc	ertification:	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	2	281. Location (Street a City or Town, Sta	und Number or Rural R te)	oute Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	0	29a. Certifier 1 Certifying Phys	ician: To the best of my knowled	ge, death occurred at the til	me, date and place,	and due to the cause	(s) and manner as state	ed.
he Ho in 24 i he Fu pletel	Medical	(Check only 2 Medical Examin	er: On the basis of examination a and manner stated.	and/or investigation, in my o	pinion, death occurr	ed at the time, date a	nd place, and due to the	e cause(s)
To 1	2	29b. Signature and title of certifier	, /	29c. Licens	e number	29d. D	ate signed (Month, Day	v, Year)
		Hice 1750	4	144	13774	Ju	4 EZ 2	रेकार्
0		30. Name and address of person who con	ipiered cause or death (Item 23a	(Type, Print)	17- 1	lictory	more 19	
	tate	31. Date filed (Month, Day, Year)	32 Registrar's Signature	Locale »	, 10 (4)	HINGUM.	mor/9	44
Regis	trar	H H H H H Z H ZUUR	A RANGE STATE STATE OF STATE O	18 John Storm				

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State Registrar 31. Date filed (Month, Day,

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ALING HUG

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

25

2008

or Print in Black Indelible Ink. Ensure All Copies Are Legible. ND TTEM#31 perDVR,C881,7/23/08,WS ate of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2008 23737 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JuÏy 20, 3:00A M FRANCES BROCKWELL WELLER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 16 Murdock Road Baltimore | If Under 1 Year | If Under 24 Hrs. | Nonths | Days | Hours | Min. | Aug 21, 1923 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XX 230-12-2588 84 Virginia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hyglene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2√XNo Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 items 23a 16 Murdock Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② Who If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. Specify: White Completed by 3XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Nurse Hospital artment of Health and Mental Hyg ortant: If item 27 is marked other Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph Ashland Brockwell Ida Mae Mann ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. Charles Roy Weller Jr Son |16 Murdock Road Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Parkwood Cemetery July 23,2008 Parkville, Maryland ☐Donation 5☐Other (Specify) 22. Name and Address of Facilit Mitchell-Wiedefeld Funeral Home Inc gnature of Fune 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or c shock, or heart failure. List Approximate Interval Between Onset and Death ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** 10ez S /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 212 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No ٩ 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Medical Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director 6 ☐ Could not be 3 ☐ Sulcide within 24 hours af er de

To the Funeral Directo

completely filled i by ti 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number D0003P3 30. Name and address of person who compared cause of death (Item 23a) (Type, Print) CARLOS AR 31. Date file (Month, Pay, Year) 32. Registrar's Signature

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State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2008 Physician WATKOWSKI FRANCES July 16, 6:25P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Maria Health Care Center Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 219-22-8443 83 **Director** Feb.14,1925 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ∏Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6401 North Charles Street 21212 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. XXNever Married 2☐ Married 1 ☐ Yes 2**XX**No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2√No ģ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Parochial School permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 Is marked other the any injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adam Watkowski Frances Witkowski ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sr. Bernice Feilinger SSND 6401 North Charles Street Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XX urial 2 ☐ Cremation 3 ☐Removal from State Villa Maria Cemetery 7-19-08 | Glen Arm, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. Funeral Service 6500 york road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Athorosclaro **Physician** padoip disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 mont Month Day Year 5 ☐ Other (specify) 9☐Unknown 9 Unknown signed by it be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy certificate 2 Z No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Pla e of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No ဥ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 1 Natural
Accident 5 ☐ Pending investigation neral Director: A 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature 29d. Date signed (Month, Day, Year) Hittondeva 10028673 amilo Mycroan July 19, 2008 1 who completed cause of death (Item 23a) (Type, Print) Svite SIDS street,

DHMH 17 Rev 1/2001

State

Registrar

Manles

32. Régistrar's Signature

JUL 2 3

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31. Date filed (Month,

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 5:50 AM BETTY WILLIAMS 2008 4a. Facility Name (If not institution, give street and number) SEASON'S 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL CENTER- HOSPICE RANDALLSTOWN BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) MD 8. Date of Birth 1 □ M 2**X**□ F 219-01-4417 87 11/14/1920 Usual Residence of Decedent

10f. Zip Code

1 □Yes 2 🕱 No

21215

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify

10d. Inside City Limits

10g. Citizen of What Country?

Specify:

USA

14. Race - American Indian, Black, White, etc.

WHITE

1 XYes 2 □ No

10c. City. Town or Location

BALTIMORE

**Physician** /Medical Examiner

Physician

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite

pormit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If Item 27 Is marked other the any liqury or other traumatic event, the Orice.

Baltimore, Maryland 21215-0036

death with the Maryland

/Medical

10a, State

MD

11. Marital Status

10e. Street and Number

Director

Funeral

10h County

4006 CLARKS LANE

1 Never Married 2 Married

N/A

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

and burial-tran signed by the attending physician I be detached for use as the burial been has

The law requires that the death certificate be executed certificate nours after death.

neral Director: After this y filled in by the funeral di this To the Hospital of within 24 hours a To the Funeral D

Division of Vital Records, P.O. Box 68760,

the Hospital or Attending

If Yes, Give Year or Dates: Ď 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER** PAPER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DAVID CORMAN ဂ္ BESSIE LEVIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PAUL WILLIAMS / HUSBAND 4006 CLARKS LANE, BALTIMORE, MD 20b. Place of Disposition (Name of SHARE) Crematory of other PARK 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dopation 5 ☐ Other (Specify) 07/22/2008 RANDALLSTOWN, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): ISCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Dav Year I □Yes 2 □ No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No autopsy performed 2 NO 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) HOSPICE 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H4593 20, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 REISTERSTOWN Deboran MAIN STREET 31. Date filed (Month, Day, Vear) . Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician YOUNG 1034 PM JULY 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOWARD COLUMBIA COUNTY GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1 ☐ M 2 🛛 F California January 23, 1927 81 Director 315-48-7790 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 👿 No Directo Maryland Anne Arundel Laurel the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 7 20724 USA 3348 Crumpton South Funeral 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or Item edical Examiner n Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Item 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Š Asian 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) other traumatic event, 17. Father's Name (First, Middle, Last) Be Hi deko ပ Yoshiyuki Kanzawa Iwanami 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael Young- son 4915 Beech Street, Shady Side, Maryland 20764 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ± ± 5 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemtery | July 22,2008 Crownsville, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Fleck Funeral Home, M01234 7601 Sandy Spring Rd., Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ARDS /Medical Due to (or as a consequence of): **Examiner** ASPIRATION PNEUMONIA Sequentially list conditions, if any 12 lines, limited cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed SEPTIC SHOCK attending physician and for use as the burial-trai Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.O. | been signed by the should be detached Q I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 21 No END STAGE RENAL DISEASE 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 No 1□ Yes Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) al director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide ō within 24 hours a

To the Funeral I

completely filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)63242 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LITTLE PANXENT PARKWAY SUITE 200 COLVMBIA MD 2/044 SHAH 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 2 3 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 9:28 Ам EMORY A. ARCHER, JR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY TAKOMA PARK WASHINGTON ADVENTIST HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖫 F 61 229-62-4687 Director 01/29/1947 VIRGINIA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at ↑ Yes 2 No Director PRINCE GEORGES BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5705 UNION BRIDGE COURT Funeral 20720 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give <sup>Δ</sup> Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Secondary (0-12) PRIVATE PROGRAM MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GLADYS JOHNSON EMORY ARCHER, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5705 UNION BRIDGE COURT BOWIE, MD 20720 TONYA ARCHER/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Injury 4 ☐ Donation 5 ☐ Other (Specify) HARMONY MEMORIAL PARK 07/08/2008 LANDOVER, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME any Ir DY IVULTA 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician levolic Cardiovasa /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has e 2 s this certificate har ral director, page 1 ☐ Yes 2 ☐ No 1 □Yes 2 ☑No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After the 27. Manner of Death 28a. Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Division 1 ☑ Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. MD 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0066 6 600 07-03-8 A GMINA H 4men 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TA Hom ( ~ 4 AHMED Sast 31 BLUD University SIDV 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

4

ORIGINAL

2008

1 9

Months

7. Age (In yrs. last birthday,

10c. City, Town or Location

85

State of Maryland / [

4b. City, Town, or Location of Death

SAlisbury
If Under 14 Hrs.
Min

Davs

Hours

Min

Department of Health and Mental  Certificate of Death	Hygiene 2000	2271.2
Certificate of Death	Beg. No. 2 UUO	23142

2. Date of Death

Month

6

Day

08

4c. County of Death

Wicomico

30

8. Date of Birth (Month, Day, Year)

JUNE 22,1923

3. Time of Death

1134

9. Birthplace (State or Foreign

10d. Inside City Limits

MARYLAND

**Physician** /Medical Examiner

1 - State Registrar

10a State

218-16-8947

Usual Residence of Decedent

1. Decedent's Name (First, Middle, Last)

JAMES LEVAN BRIDGES

10b. County

4a. Facility Name (If not institution, give street and number)

Peninsula Regional Medizal ( 5. Social Security Number / 6. Sex 7. Age

**Funeral** Director

23a or 28a-f show

RK G+IVA

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is itedical Examinat must be notified at once. 1 XYes 2 □ No Director MD WICOMICO SALISBURY 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 1105 SOUTH SCHUMAKER DR., APT 005 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: ģ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 MAINTENANCE SUPERVISOR PUBLISHING CO. s 1 and 2 should be filed wi f Health and Mental Hygier item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ CLEVELAND BRIDGES MARY FISCHER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLAUDIA BRIDGES/WIFE 1105 SOUTH SCHUMAKER DR., APT 005, SALISBURY, MD 20c. Location - City or Town, State 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PARK 7/7/2008 EASTON, MARYLAND 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST., EASTON, MD 21601 21. Signature of Funeral Service Licenses Joseph Ustiwush: Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 24 4day) **Physician** -omplication Hip Fracture disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) burial-trar Physician: The law requires that the death certificate be execu Due to (or as a consequence of) IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed COPD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No CAD 1 □ Yes 2 No Division of Vital 1 ☐ Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1**X**Yes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After Hospital or Attending 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 No 2 Accident investigation 6/24/08 Fall off Swoter 1400 hin 24 hours after death the Funeral Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1105 S. Schundter Dr. Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tiple of cer H50496 DWF CHRISTOPHER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ast SNUDER DO.DME arroll gistrar's Signatur Ye 0 3 2008 State Registrar DHMH 17 Rev 1/2001

08-05468	
Irving Binder	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

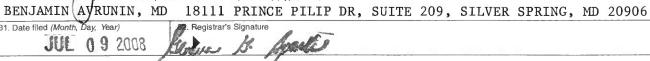
		1- For State Control of Prealth and Wentan in Certificate of Death Registrar		20 ( Reg. No.	18 2374
Physicia	n/	Decedent's Name (First, Middle,Last)	2. Date of De Month		3. Time of Death
Medical Examir		Irving Myer Binder  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Deatl	July 16, 2	2008 4c. County of Deat	1220 hrs
		Holy Cross Hospital  Silver Spring	11	Montgomery	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	s. 8. Date of B	irth(MM/DD/YYYY) 9. Bi	
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any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show any d at once,	ö	MD Montgomery Silver Spring			1 X Yes 2 No
Maryl r 28a-1 ed at o	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Cou	intry?
n with the Maryland ms 23a or 28a-f sho be notified at once		3330 N. Leisure World Blvd. #225 20906		U.S.A.	- Pinal
ath wi	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 2 Married 31. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		White, etc.	ncan Indian, Black,
her de I", or		1 X Yes 2 No 3 Widowed 4 Divorced of Pates 2 No Specify: or Dates: 1 Yes 2 X No Specify: 0 Yes 2 X No Spec		Specify: Wh	ite
hours afte "natural", Examiner	ed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use re-		16b. Kind of Business	/Industry
36 in 72 l han "r Lical E	plet	Elementary/Secondary (0-12) College (1-4 or 5+)		7.	
21215-0036 uld be filed within 72 Mental Hygiene. marked other than "	Completed	17. Father's Name (First, Middle, Last)  4 Owner  18. Mother's Name	e (First, Middle	Liquor , Maiden Surname)	
21215-(uld be filed v Mental Hygimarked oth	Be	Maurice H. Binder Sophie	Kolker		
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	٩	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or		umber, City or Town, Stat Silver	e, Zip Code) Spring, MD
md 2 sealth as	-	Ruth M. Binder - Wife 3330 N. Leisure World  20a. Method of Disposition (Name of cemetery,	Blvd.	#225 20906 20c. Location - City of	
Ore ges 1 a t of He : If it		1 X Burial 2 Cremation 3 Removal from State crematory or other place)			
Baltimore, MD 21215 permit: Pages I and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked o injury or other traumatic event, th	-	21 Streature of Funeral Service Licensee 22 Name and Address of Facility	18/2008		
De Per Ba	ł	Edward Sagel Funer 1091 Rockville Pik  23a. Part I. Enter the disease, or complications that causey the death. Do not enter the mode of dying, such as cardiac	al Dire	ction, Inc.	0852
Physician		23a. Part I. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and
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		d.	<del>ੲ                                    </del>		
60, ate be ex ohysician	Medical	X ON FINED		1	
876 tificat ing phr		IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth  2 Fetal death  3 Ectopic pregnancy	nancy	23d. Date of delive Month	ry Day Year
Box 687 death certific the attending p	Physician/	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)		9.83	
C. B. tr the de by the ached f	된	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use contribute t	the cause of death?
ires that the signed by	d b	Chronic obstructive pulmonary disease	1 _ Y	es 2 V No 3 Pro	obably 4 Unknown
ords, w requires should	Completed by		24a. Wa		utopsy findings available completion of cause of
Vital Reco hysician: The law this certificate has	E			formed? death?	res 2 No
cian:	Bec	25. Was case referred to medical examiner?	only one)		
n of Vir Jing Physic After this funeral dir	2	1 Ves 2 No Inpatient 2 VER/Outpatient 3 DOA Oute4 Nursi	ing Home 5	Residence 6 Oth	er:
on of nding Pt th.	ion	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No	200, 2000, 101	5 1151 11 July 5 5 5 5 1	
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been is led in by the funeral director, page 2 should I	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.		(Street and Number or F	Rural Route Number, City
Dir spital o ours a neral D	Cert	4 Homicide determined (Specify)	or Town,	State)	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	- 1	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an (Physician one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred			
To t with To t	Medical	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (M	
		O.C.M.E.		July 17, 2008	
	}	30. Name and address of person who completed cause of death (Item 23a)			
		Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, N	/ID 21201		
Sta Regist	ate	31. Date filed (Month, Day, Year)  32. degistrar's Signature		OCME	

			For	Type or Pring State of Ma		l / Depa	artmen	t of H	lealth	and Me	•		egible.		
		-	State Registrar			Ce	rtificat	e of	Death			eg. No. 2	008	2:	3744
	Physici		1. Decedent's Name (First, Middle, Last ROSEMARY ROBERTS 1								2. Date of Deat Month June 29	Day	Year	3. IIm	e of Death
13.	/Medic		4a. Facility Name (If not institution, give				4b. City,	Town, o	r Location		June 29	_	ounty of Death		LJF
			15100 INTERLACHEN							SPRING			MONT		
ì	Funeral Director			x 7. Age ]M 2⊠F	(In yrs. la	s <i>t birthday)</i> Yrs.	If Under Months	1 Year Days	Hours	Min.	8. Date of Birth (Month, Day, 05/22/1	Year)	9. Birth Cou TEXA	intry)	ite or Foreign
	p.		578-30-8520 Usual Residence of Decedent			Taum and					03,22,1				n City Limite
	tarylar show	ō	10a. State 10b. County	DV		Town or Lo									e City Limits Yes 2 ☐ No
	the N 28a-f notifie	Director	MARYLAND   MONTGOME  10e. Street and Number	KY	PITA	ER SP	10f. Zip	Code			1	0g. Citize	n of What Co	intry?	-
	th with 23a or ist be		15100 INTERLACHEN	DRIVE #723	3	20906							USA		
	tems tems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	13.	Was Dece If Yes, spe	dent of H cify Cub	lispanic O an, Mexica	rigin? (Spec an, Puerto P	ify Yes or No- lican, etc.)	14	Race - Amer Black, White		٦,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Exeminer must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X N If Yes, Give Year or Dates:	0		1 ☐ Yes	20 No	Specify	<i>/</i> :		S	pecify: WI	HITE	
2	72 hou natura iical E	eted	15. Decedent's Edu (Specify only highest grad	ucation le completed)	I	16a. Dece	dent's Usu	al Occup	ation during mo	st of workin	g I	16b. Kind	of Business/I	ndustry	
21215-0036	within sne.  than "  be Mec	Jdw	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 2  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  HOMEMAKER										OWN HO	)ME	
	filed withi I Hygiene. other thar ent, the M	Be Co	17. Father's Name (First, Middle, Last)				110111			ner's Name	(First, Middle, I	Maiden Su		7111	
aryland	2 should be f and Mental I is marked of raumatic eve	To B	JOHN F	JOHN ROBERTS							IREN	E FRA	ANK		
/ar	l2sho nand risma		19a. Informant's Name/Relationship (7		19b. Mailing Address (Street and Number or Rural Route Number, City or Tow										
oʻ	1 and 2 Health em 27 i		CHARLES BERNSTEIN/SON  6815 RANNOCH ROAD, BETHESDA, MARYLAND  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  Date  20c. Location - City of Cemetery, crematory or other place)											e	
ltimore,	Pages 1 ar nent of Hea int: If Item ? iry or other		1 XBurial 2 ☐ Cremation 3X 4 ☐ Donation 5 ☐ Other (Specify							07/03	/2008	FALLS	S CHUR	CH, V	IRGINI
Balti	permit. Pag Department Important: I any injury o		21. Signature of European Service Licens	21. Signature of Femeral Service Licensee  22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 2085  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate											20852
	6 6 6		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused one cause on each lin	the death. e.	. Do not en	iter the mod	de of dyi	ng, such a	s cardiac or	respiratory arr	est,		Interva	imate Between and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ARTERIOS			CARDIC	VAS	CULAR	DISE	ASE				ARS
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		ner	Sequentially list conditions, it any, reading to immediate cause. Enter Underlying	b. Due to (or as a	t curissiqu	sequence of):									
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,09				Due to (or as a	z consequ	erice or).									
68760	tificate g phys as the	ledic		d						13VH =					
Вох	death certificate be e attending physicia d for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1 □ Live birth			□Ectopic p	regnanc	y			23	d. Date of del	very Day	Year
o.	D 0 D	ysici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of de	eath 5	Other (s	pecify) _					Will the last	Duy	
<u>α</u>	The law requires that the de tte has been signed by the a age 2 should be detached		Part II. Other significant conditions co	ontributing to death bu	it not resul	Iting in the u	underlying	cause giv	en in Par	t I.	23e. Did to	bacco use	e contribute to	the cause	of death?
rds,	equires en sign	ed by									1□Y	es 2⊠	No 3□Pr	obably	4 □Unknown
Record	2 2	Completed									24a. Was a	sv		topsy find	ngs available
<u>س</u>											perfor	med? 200 No	death? 1 ☐ Yes	2□ No	
Vital	Physician: The this certificate ral director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2☑ No	Hospital: 1 ☐ Inpatie	nt 2 🗆	ER/Outpatie	ent 3 🗆 D	OA Oth	er.		(Check only or		Other (Co.	ni6 d	
o			27. Manner of Death	28a. Date of Injur (Month, Day	у	28b. Time		28c. Inju Wo			ne 5 Resid 8d. Describe h			any)	
sior	Attending r death. ector: After on the fune	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		Today	injury	М		Yes 2	]No					
Division	I or Att after de Directe i in by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injubulding, etc			treet, factor	y, office		2	8f. Location (S City or Tow		Number or Ru	ıral Route	Number,
	• Hospital or Attendi 24 hours after death. • Funeral Director: A etely filled in by the fu	29a. Certifier (Check only one)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as and manner stated.										use(s)			

State Registrar 31. Date filed (Month, Day, Year) JUE 0 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and little of certifier



29c. License number

D08381

29d. Date signed (Month, Day, Year)

JUNE 30, 2008

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 2105 M Bui Hong 07 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Montgomery 01 nev 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F Months Director 83 212-43-8752 December 31, 1924 Vietnam Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show d other than "natural", or Items 23a or 28a-f show event, the Wedical Examinar must be natified at 1 □Yes 2 V No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 16314 Whitehaven Road 20906 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 🕱
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 X No Specify. Specify. \$ 3 ▼ Widowed 4 □ Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Pharmacist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) it and 2 should be file.
I Health and Mental H
tem 27 is marked oth Be Sinh Thi Pham traumatic ဥ Bo Bui 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Ann Bui - Daughter 16314 Whitehaven Road, Silver Spring, Maryland 20906 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 07/13/2008 Brentwood, Maryland 21. Signature of Funeral Service L 22. Name and Address of Facility **Hines-Rinaldi Funeral Home, Inc.** 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician CHOKING BY DENTURE disease or condition resulting in death) /Medical Examiner ENCEPHALOPATH HYPOXIC Sequentially list conditions, IN Pro Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit and be exect Due to (or as a consequence of): Physician/Medical the as attending IF FEMALE: use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEcton ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other signed by the a d be detached fi P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has was ... autopsy performed ves 2000 certificate 1 ☐ Yes 2 🗆 No 1 ∐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1**∑**Yes 2 🗌 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this funeral 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: PATIENT CHOKED ON HIS DENTURES 1 Natural 5 Pending Injury 05 12008 2 P 1 ☐ Yes 2 No 2 Accident investigation IN HIS KITCHEN. 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 16314 WHITEHAVEN RD OLNEY MD HOME 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one To the twithin 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe nung 2008 08 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 20832 PRINCE PHILIP DR DLNEY 18101 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 09 Registrar 2008

9-Counter signisture stamp of per Di Brabons

			For State	State of I	Maryland /		artment of F		nd Mental Hy	_	000	007	1 0
			Registrar  1. Decedent's Name (First, Middle, Last)			Cei	lilicate of t	Jeain	2. Date of De	Reg. No.	008	3. Time of D	46
	Physici		MARY ALICE LOUISE						Month 07	Day 05	Year 2008		eau Μ
100	/Medi Examir		4a. Facility Name (If not institution, give		er)		4b. City, Town, or	Location of D			ounty of Death	10:00	<u>A</u>
			14105 MARY BOWIE PA	ARKWAY			UPPER MA	RLBORO		PRI	INCE GE	ORGES	
I	Funeral		5. Social Security Number 6. Sex 577-30-4794	7. M 2 □ XF	Age (In yrs. last b.	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Da	h y, Year)	9. Birth	place (State or i	Foreign
	Director		Usual Residence of Decedent			115.			09/22/1	918	SOUT	H CAROL	INA
	yland how		10a. State 10b. County		10c. City, Tov	vn or Lo	cation				1	10d. Inside City	Limits
	e Mar la-f sl	cto	MD PRINCE GI	EORGES	UPPER	MAF	RLBORO					1∭Yes 2	!□No
	라 다 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cou	ntry?	
	s 23a	eral	14105 MARY BOWIE F			T	20774			USA			
	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Deceder Armed Force 1 ☐ Yes 2 [	s?	13. V	Vas Decedent of H Yes, specify Cuba	spanic Origin n, Mexican, P	? (Specify Yes or No Puerto Rican, etc.)	14	<ul> <li>Race - Americ Black, White,</li> </ul>		
03	urs at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date		1	□Yes 2MNo	Specify:		S	pecify: BL	ACK	
2- 2-	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, tre "Kedical Exa "ill at must be restlifted at	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a	a. Deced	lent's Usual Occupa	ation	working	16b. Kind	of Business/In	dustry	
121	/ithin ine. <b>han</b> "	ш	Elementary/Secondary (0-12)	College (1-4o	′	life. L	OO NOT use retired	)	Working				
7	iled v Hygie ther t		8TH 17. Father's Name (First, Middle, Last)		H	OMEM	IAKER	10 Mathada	Name (First, Middle,	PRIV			_
an	be od o	To Be	THOMAS BELTON					ALICE 1		iviaigen St	irname)		
Maryland 21215-0036	should be and Menta s marked	F	19a. Informant's Name/Relationship (Typ	oe. Print)	191	b. Mailin			or Rural Route Numbe	er. City or T	own State Zir	Code)	
	and 2 ealth a n 27 is er tra	n j	LESLIE P. BRITT/SC						RKWAY UPPE				74
Ψ	of Fer	Ш	20a. Method of Disposition		namoto	of Dispos	sition (Name of latory or other place	e) ;	Date	20c. Loca	tion - City or To	wn, State	
Ĕ	it. Pages rtment of l rtant; If its njury or o		1 ∰ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from Stat	ie   /	AND	VETERANS	07,			ENHAM,		
Za Za	permit. Pag Departmen Important: any injury once.		21. Signature of Funeral Solvice Livense	е					J.B. JENKI			HOME	
_	<u> </u>		13		>				AD LANDOVE		20785		
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Corse (Final	ations that caus e cause on each	ed the death. Do line.	not ente	1	1	rdiac or respiratory ar	rest,		Approximate Interval Betwe Onset and De	en
1	hysician /Medical		disease or condition resulting in death)	11	cheim		Hen	rente	-CR			Crisci and Dec	
	xaminer			Due to (or a	as a consequence	of):							
		je	Sequentially list conditions, if any partial transport of the cause. Enter Underlying Cause (Disease or injury	Due to (pre	es a consequence	uf):					-	<del></del>	
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00/00	incate be executed physician and s the burial-transit	dical	d.									<del></del>	
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ם מ	atter of for u	ciar	in the past 12 months?	1 Live birth	2 ☐ Fetal death at time of death		Ectopic pregnancy Other (specify)			230	<ol> <li>Date of delive Month</li> </ol>	ery Day Yea	ar
5	by the achec	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown			Other (speedity)						
ָר נְּלָּי	gned	by P	Part II. Other significant conditions cont	ributing to death	but not resulting in	n the un	derlying cause give	n in Part I.	23e. Did to	bacco use	contribute to th	ne cause of dea	th?
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	cate h	S							— autops perfor 1 □ Yes	med? 2 🖾 No	death?	npletion of caus 2 🖾 No	se 01
VILLE	h. After this certificate has been signed by the funeral director, page 2 should be detached	Be	25. Was case referred to medical examiner?				1		Death (Check only or	re)			
5	r this	٤.	1 Yes 2 No	ospital: 1 ☐ Inpa 28a. Date of In	tient 2 ER/Ou	utpatient Time of		4 LI Nursin	g Home 5K Resid			v)	
5 5	th. Afte	ţi.	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	Day, Year)	njury	28c. Injury Work? M 1 □ Y	es 2∐No	28d. Describe h	ow injury o	ccurred		
10 To	r dea ector by the	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Ir	njury - At home, fa	ırm, stre			28f. Location (S	reet and N	lumber or Rura	l Route Number	r.
$\frac{1}{2}$	s afte	Sert	4 ☐ Homicide determined	building, e	etc." (Specify)				City or Tow	n, State)			,
the Hoenitel of Attending Divisions The Journal of Attending Divisions The Journal of Attending Divisions to the Journal of Attending Divisions to the Journal of Attending to the Journal of Attendin	within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun	Medical	29a. Certifier rtifying Physi (Check only one) 2 ☐ Medical Examine	cian: To the bes er: On the basis and manner s	of examination an	e, death nd/or inve	occurred at the timestigation, in my op	e, date and pl inion, death o	lace, and due to the occurred at the time, o	ause(s) ar ate and pla	nd manner as s ace, and due to	tated. the cause(s)	
o the	orthin compl	Me -	29b. Signature and title of certifier	and mariner s	nateu.		23c. License	number		9d. Date s	igned (Month, I	Day, Year)	
\	1		1 /Januala	X/Q1	2	)		5323		7/	7/09	y,/	
	120	1	30. Name and address of per in who com	pleted cause of	death (Item 23a)	(Type. P		フノムン	>	//	1100	_	
	200		DARRYL HILL M.I				•	UREL.	MARYLAND	20904	, 4		
	Stat		31. Date filed (Month, Day, Year)	32. Regis	trar's Signature						-		
	Registra	ar I	JUL 0 9 2008	and a PA	hours.								

DHMH 17 Rev 1/2001

Division or Vital Records, Physician: funeral director After this To the Hospital or Attending I within 24 hours after death.

To the Funeral Director; After the 1

28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1XX Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s)

D53235

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year) 07/07/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Darryl Hill, M.D. 13635 Baltimore Ave., Laurel, Maryland 20707

State Registrar

Certification:

Medical

filled in by

32. Registrar's Signature 31. Date filed (Month, Day, Year) JUL 1 0 2008

State of Maryland / Department of Health and Mental Hygien ?

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Marjorie Yvonne Barbour July 2008 21:09 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 F 227-38-5218 1934 73 Virginia July 6, Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Prince George's Hyattsville 1KDYes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4002 Ingraham Street 20781 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. African 11. Marital Status 1 ☐ Yes 2 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ≥ Specify: 3 ☐ Widowed 4 X Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew Barbour Norma Carter 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Chancey - Daughter 179 Newton Street Meriden, CT 06450 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 K Burial 2 □ Cremation 3 □ Removal from State Washington Nat'l Cemt. July 11, 2008 Suitland, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4001 Benning Road, NE Washington, DC 20019 23a. Part 1 Street the disease, or complications that caused the shoot of eart failure. List only one cause on each line. Approximate Interval Between Onset and Death ode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated as early Due to (or as a consequence of) Examine that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Yes 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 21 No. pade certificate 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital: 1 ☐ Yes 2 Other: 2 TER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) npatient 27. Mann of D Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: or Attending (Month, Day Year) 1 Valural Injury 5 ☐ Pending investigation 1 □ Yes 2 □ No Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours of the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c, License number 29b. Signature and title 29d. Date signed (Month, Day, of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Wear State 2008 Registrar

DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	——————————————————————————————————————		rtificate of D		entai mygii Reg	2008	23749
	Physic /Medi			CONDIT				2. Date of Death Month JULY 7	, <sup>Day</sup> 2008 Year	3. Time of Death 9:51 P M
1	Exami	ner	4a. Facility Name (If not institution, give FREDERICK MEMORIA			4b. City, Town, or L			4c. County of Death FREDERIC	K
	Funeral Director		402-00-1943	7. Age (III	yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, OV 27,	year) g. Birthp Coun 1958 Maryl	elace (State or Foreign stry) and
	Maryland -f show	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland Prince Ge		c. City, Town or Lo				10	0d. Inside City Limits 1 □Yes 2 🕅 No
	be filed within 72 hours after death with the Maryland ntal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Evanting must be notified at	eral Director	10e. Street and Number 3604 41st Avenue		olmar Man	10f. Zip Code 20722		US	g. Citizen of What Coun	
900	ours after de ral", or item	by Funeral	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Vas Decedent of Hisp fYes, specity Cuban, □Yes 2 <b>X</b> INo	panic Origin? (Spec Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Americ Black, White, e	etc.
Baltimore, Maryland 21215-0036	within 72 he jiene. r <b>than "natu</b> he wedieri	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	(Give	lent's Usual Occupati kind of work done dui DO NOT use retired)	ion ring most of working	,	6b. Kind of Business/Inc	lustry
and 2	wild be filed Mental Hygi arked other atic event, the	Be	17. Father's Name (First, Middle, Last) Billy Monroe Cond:		waitie	1	8. Mother's Name (	First, Middle, Ma	,	
Mary	2 sho	2	19a. Informant's Name/Relationship (7) Wiley R. Condit/ur	/pe. Print)	19b. Mailin		ohnnie Fa d Number or Rural ie Colmar	Route Number, C	City or Town, State, Zip	Code)
more,	Pages 1 and nent of Health int: If Item 27 iry or other t		20a. Method of Disposition 1 ☐ Burial 2 【☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		0b. Place of Dispos cemetery, crem	sition (Name of latory or other place) e Cremator	Da	te 20	c. Location - City or To	
Balti	permit. Pag Department Important: I any Injury o once.		21. Signal of Funeral Service Licens	04	G <sub>O</sub> <sup>22</sup>	Name and Address	of Facility Cremation	Service	P.O. Box	784
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caused the ne cause on each line.  Due to (or as a core).	Do not enter  Pulm  nsequence of):	er the mode of dying,	such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Medical Examiner	Seculentially est according to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a cor Due to (or as a cor	obsta	nctive	Pulmon	any di	reace	
P.O. Box (	the death certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver	ry Day Year
ords, F	w requires that the de s been signed by the a should be detached f	þ	Part II. Other significant conditions con	ntributing to death but not	t resulting in the und	derlying cause given i	in Part I.		cco use contribute to the	e cause of death?
		Completed	25. Was case referred to medical						prior to com	sy findings available npletion of cause of
>	ysici s cer direct	o Be	examiner?	ospital:	2 T FR/Outrations	Othor	6. Place of Death (			
io uo	Attending Physician: r death. ector: After this certific by the funeral director,	Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Yea	2 ER/Outpatient 28b. Time of Injury	28c. Injury at Work?		d. Describe how i	e 6  ☐ Other (Specify, injury occurred	
Divis	ital or Atte irs after de al Directo led in by th	Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Sp	281	Location (Stree City or Town, S	et and Number or Rural State)	Route Number,		
:	Io the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	one)	ician: To the best of my ner: On the basis of exar and manner stated.	knowledge, death mination and/or inve	occurred at the time, estigation, in my opinion	date and place, an ion, death occurred	d due to the caus at the time, date	se(s) and manner as sta and place, and due to	ated. the cause(s)
	To wit	Ž	29b. Signature and title of certifier	MB		29c. License no			Date signed (Month, D	**
(L	1)02		30. Name and address of person who co Hemen Shah	65-C The	mas -	rint) Tolunsan	DV	Freder	MICK MD	2170)
	Stat	е	31. Date filed (Month, Day, Year)	32 Registrar's Si	ignature	A. A.				

DHMH 17 Rev 1/2001

			1 - For State Registrar	Otato or i	viai yiai i		rtificate			vicinairi	Reg. No	<b>Z U</b>	08	23/50
7	Physici	an	1. Decedent's Name (First, Middle,	Last)						2. Date of D	eath Da		Year	3. Time of Death
	/Medic		WILLIAM SAM				_			July	6		8008	1276 W
Spiral.	Examir	er	4a. Facility Name (If not institution, The Memori		4		1		cation of Death	1	40	County		
_		, il		1 1001	Age (In yrs. I	ast hirthday		Eas Year I If	Under 24 Hrs.	8. Date of B	irth	1 a	160T	lace (State or Foreign
	Funeral Director		214-38-7561 Usual Residence of Decedent	1 <b>X</b> M 2□ F	66				Hours Min.	AUGUST	ay, Year		Coun	YLAND
	fand ow at		10a. State 10b. County		10c. City	, Town or Lo	ocation						10	0d. Inside City Limits
	Mary Ifed	tor	MARYLAND OUT	EEN ANNE'S		STEV	ENSVIL	LE.						1 ☐ Yes 2 XNo
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	er dea	Funeral	11. Marital Status	12. Was Decede Armed Force	s?	S. 13.	Was Deceden If Yes, specify	t of Hispa Cuban, N	anic Origin? (Sp Mexican, Puert	pecify Yes or N o Rican, etc.)	lo-		e - America k, White, e	
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 📉 Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 ☐ If Yes, Give Year or Date			1 □ Yes 2 <b>2</b>	(No S	Specify:			Specify	WHI	TE
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d 2	filed Hygid Ither	သို့	17. Father's Name (First, Middle, L	ast)		SHEE	1 KUCK			ne (First, Middle				/N
Maryland	should be and Mental marked o	To Be	WILLIAM SAMU	T. CARSON.	.TR.					IA NEIG			-/	
ary	shoul nd M mar	F	19a. Informant's Name/Relationsh		OK.	19b. Maili	ng Address (S	treet and		ral Route Num			State, Zip	Code)
ž	and 2 ealth a n 27 Is		MARY CARSON/WIJ	Æ		210	COCKE	Z LAN	NE, STE	<b>VENSVI</b> L	LE,	MARY	LAND	21666
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Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service L	icense			2. Name and A ELLOWS, D6. SHAM	HEL ROCK	FENBEIN	AND NI	EWNAI	M FUN	IERAL	HOME, P.A
la:	104-153	П	23a. Part1 IIII in disea , or o shock, or heart fai ure. List o	complication that cau	d the death							TKI LE	MD Z	Approximate
	Physician		Immediate Cause (Final disease or condition		EMIC.	_	DIDMY							Interval Between Onset and Death
7	/Medical		resulting in death)	Due to (or	as a consequ	ence of):							_	
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ų.	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	ence of):						- 77		
	rtificate be executed ng physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C										
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68760,	physicate physicate	Medical		d										
ox (	certif nding use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	ne pf pregnai	ncy						23d Dat	e of delive	n.
m	or Attending Physician: The law requires that the death ce fret death.  Director: After this certificate has been signed by the attendir in by the funeral director, page 2 should be detached for use	Physician/I	in the past 12 months?	1 ☐Live birth 4☐Pregnant	2 ☐ Fetal at time of de	death 3[	⊒Ectopic pregi ⊒ Other <i>(speci</i>					Moi		Day Year
P. 0.	t the o	hysi	9 Unknown	9□Unknowr	1									
	s tha	by P	Part II. Other significant condition	s contributing to death	but not resu	lting in the u	inderlying caus	e given ir	n Part I.	23e. Did	tobacco	use contr	ibute to th	e cause of death?
ğ	equire									1,72	Yes 2	2□ No	3 Prob	ably 4 ☐Unknown
Vital Records,	has be	Completed								24a. Wa	s an opsy	24b. V	Vere autop	psy findings available npletion of cause of
<u> </u>	ysician: The ils certificate ha director, page	E								perl	formed? 2 <b>X</b> N	0	leath?	22No
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ō	Physi this c	2	1 Yes 2 No				nt 3 DOA		4 ☐ Nursing H	ome 5□Res				)
u C	ding F h. After funera	ion	27. Manner of Death  1 ☒ Natural 5 ☐ Pending		Day Year)	28b. Time o Injury	т   28с. М	Injury at Work?	2 🗆 No	28d. Describe	how inju	iry occurr	ed	
Division or	death death ctor: y the	Certification:	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be 290 Place of	iniury - At hor	me. farm. str			2 🗆 No	28f Location	(Stroot a	nd Numbe	er or Rura	I Route Number,
<u>&gt;</u>	after Dire	ertii	4 ☐ Homicide determin	ed building,	etc. (Specify	)	oot, lastery, o			City or To	own, Stat	e)	or or maran	Hoale Namber,
	spita neral y filled		29a. Certifier 1 Certifying	Physician: To the be	st of my knov	vledge, deat	h occurred at t	the time,	date and place	, and due to the	e cause(s	s) and ma	nner as st	ated.
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical E	xaminer: On the basis and manner	of examinat	ion and/or in	vestigation, in	my opini	on, death occu	rred at the time	e, date ar	nd place, a	and due to	the cause(s)
	To the vithing to the complex	ž	29b. Signature and title of certifier	6-		_		cense nu		7 -	29d. Da	ate signed	(Month, L	Day, Year)
	(, -		John	Bolow				1) 00	9948	1		07	1071	08
	MS		30. Name and address of person w											
	1		JOHN BOTSIS, M.D				STREET	r, EA	STON, 1	MARYLAN	D 21	601		
	Sta Registr		31. Date filed (Month, Day, Year)	2008	strar's Signat	de de	ante							
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This lo

31. Date filed (Month, Day, Year) 2008 33 Registrar's Signature

Assistant Medical Examiner

address of person who completed cause of death (Item 23a)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

July 3, 2008

Registra

Laron Locke MD

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Alan Jeffrey July 5:44 p Cohen 7, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 735 Sligo Avenue, Apt. Montgomery

9. Birthplace (State or Foreign 5. Social Security Number 6. Sex If Unde 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace Country) **Funeral** Months Days Hours Min. 1 □ M 2 □ F Director 100-32-5242 April 18, 1941 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Martal Hygiene.
Important: I fem 71 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is fracticed Exp. nink must be notified as Director 1 ☐ Yes 2X No Maryland Spring 10f. Zip Code Montgomery Silver. 10e. Street and Number 10g. Citizen of What Country? 735 Sligo Avenue, Apt. 204 Funeral 20910 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify: White Specify. þ 3 ☐ Widowed 4 🖰 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Systems Analyst Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cohen George Adele Myers ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Cohen/Daughter 12049 Eaglewood Court, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 2008 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd.. W. Silver Spring, MD 20901

Approximate Interval Between Onset and Death رجعا 23a. Part1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Cardiac Arrest /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <del>since 1999</del> Due to (or as a consequence of): Examine Physlcian: The law requires that the death certificate be executed Valvular Heart Disease and burial-trar since 1999 Due to (or as a consequence of): Box 68760 Left Ventricular Hypertrophy Physician/Medical since 1999 the attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Diabetes Mellitus 1 TYPes 2 No 3 Probably 4 Unknown should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s performed? certificate 1 ☐Yes 2 ☐ No this certific al director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🙀 Residence 6 Other (Specify) 1 ☐ Yes 2 █No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Natural 5 Pending Injury within 24 hours after death.

o the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🅰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٩ D53523 July 8, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brenda Mitchell, MD 912 Thayer Avenue, #101, Silver Spring, MD 20910 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 09 Registrar 2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year 6:28 AM William Lullaw Damnosc 07 3005 <u>ت</u> ک 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death acreal Migital Columbia Hours If Under 1 Year If Under 24 Hrs. 5. Social Security Number .Sex 1**X**M 2∐F 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days Hours 155-22-6340 77 Dec. 1930 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □Yes 2 X No Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 10126 Hyla Brook Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11, Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Certified Public Accountant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Ludlow Damrosch, Sr. Dorothea Donahoo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Damrosch/wife 10126 Hyla Brook Road Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Chesapeake Crematory | 07/10/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Ischenic Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Charce Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown

Physician /Medical Examiner

certificate be executed

Box 68760,

P.0.

Records,

or Vital

Division

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director MD

Funeral

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Completed

Be

ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f sh Injury or other traumatic event, the Medical Examiner must be notified

permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien. Important: if Item 27 is marked other the any Injury or other traumaric avent \*\*\*

Maryland 21215-0036

Baltimore,

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Examine Be

attending physician Physician/Medical the as nse for the detached þ Completed peen has certificate ၉ this After

e Hospital or Attending P 24 hours after death. e Funeral Director: After t Certification: in by the completely filled Medical

To the Hospital within 24 hours at To the Funeral C 14 State Registrar

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

21287

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

4 Homicide

29a. Certifier

29c. License number

Baltone, MD

29d. Date signed (Month, Day, Year,

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼No

RES - 0000

08/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Singh 31. Date filed (Month, Day Year)

**JUL 10** 

N. Walle 600 32. Redistrar's Signature

and manner stated.

Amend Items

State of Maryland / Department of Health and Mental Hygiene
23a,25,27,28a-f pertine 9882,08/08/08dhb Reg. No. 2008 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Physician Year 807 M Henr XON 28-2008 Ohn lo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 Hosp. fal 7. Age (In yrs. last birthday) ambridge orchester General Dorchester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 218-58-2298 1 1 M 2 □ F Director JUNE Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits iral", or Items 23a or 28a-f show Examiner must be notified at 1 res 2 No Funeral Director Dorchester ambridge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Wood 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 11. Marital Status Black, White, etc. 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: <u>ک</u> 3 Widowed 4 Divorced Black "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within on the filed within on the strange of Health and Mental Hygiene. College (1-4or 5+) of Health and Mental Hygiene. Elementary/Secondary (0-12) AutoMotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be D'XON, SR. | Helen Ouella ...

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ို John Henry 19a. Informant's Name/Relationship (Type. Print) Daughte 703 Peachblossom

20b. Place of Disposition (Name of cemetery, crematory or other place)

Disposition (Name of cemetery, crematory or other place) Ave, Cambridge, MD. 21613 Peggy 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐Burial 2 ☐Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part i. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical consequence of): Examiner OVE Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) APPROVED BY MEDICAL EXAMINER Examiner bdomyol CERTIFICATION Due to (or as a consequence of): Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) o been signed by the should be detached 9 ☐ Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division or Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Co Caine 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 27. Manner of Death
1. Whatural
2 Accident 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation I Director: A Unknown<sup>M</sup> Unknown 1 ☐ Yes 2 ☐ No Unknown 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Unknown Unknown within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation is a stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Labib 06 2-00 PM TLS who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 300 Byrn Labib Street (ambr Ahmed 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 2 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

APRIL THE DESTRUCTION OF THE STATE OF MARYLAND TO BE STATE OF MARYLAND TO BE STATE OF MARYLAND TO BE STATE OF THE STATE OF Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** IRMA W. DAVIS 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death **Examiner** PRINCE GEORGES DOCTORS COMMUNITY HOSPITAL LANHAM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 08-22-1922 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🛱 F Months PENNSYLVANIA 85 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the medical Eventies is ust be rectified at XXYes 2 □ No Director PRINCE GEORGES SPRINGDALE MD10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with Funeral 3611 JEFF ROAD 20774 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify Specify: BLACK þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) GOVERNMENT n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **SECRETARY** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FRANCES JOHNSON THOMAS B. WITHERSPOON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any Injury or other trau once. 1409 ROSEMARY COURT BOWIE, MD 20721 KEITH T. DAVIS/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HARMONY MEMORIAL PARK 07/08/2008 LANDOVER, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility JB JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ardiopulmonary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner aspiration hours if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Sepsis Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 5 Other (specify) Division of Vital Records, P.O. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Abdominal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 DNo 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7/3/2008 D37934 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NE

State 31. Date filed (Month, Day, Year)
Registrar
JUL 0 9 2008

Stephanie

32. Registrar's Signature

Trifoglio, MD

7500 Greenway Center D. Greenhelt MD 20770

			State of Maryland / Department of Health and M 1 - State Amend #1, perMD, #19a, perFH, C881, 7/23/08 TT Registrar	lental Hy	giene Reg. No. 2	008	23757
ch.	Physici	an	1. Decedent's Name (First, Middle, Last) Nettie M. Dixon	2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic		Nettie Ny Dixon	Ju1y		800	13:28P M
X	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death			ty of Death	eorges
_4	Funeral		Southern Maryland Hospital Clinton  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bi	rth	9. Birth	place (State or Foreign
1	Director	Ų.	577-56-0966 1 M 20 F 65 Yrs. Months Days Hours Min.	(Month, Da	-1942	So.	Carolina_
	w w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits
	//aryla f sho	ō	DC Washington, D.C.				1- Yes 2 □ No
	28a-	Director	10e. Street and Number 10f. Zip Code		10g. Citizen o	f What Cou	ntry?
	h with		201 58th Street, N.E. Apt. 305 20019		Т	JSA	
	ems a	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerlo	ecify Yes or No Rican, etc.)		ace - Americack, White,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1 □ Yes 2 ▼ No Specify: Year or Dates:		Spec		lack
21215-0036	hour htural	ed b	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of	Business/In	dustry
215	hin 72 9. an "ng Medic	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of worki life. DO NOT use retired)	ing			,
	ed with	Com	12 Clerk Typist				ndustry
nd	be file	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name  To August 19.	, ,		ame)	
Maryland	d Mer narke	P	John F. Blake Gracie  19a. Informant's Name/Relationship (Type. Print)  19b_Mailing Address (Street and Number or Rura			04-4- 70	- 0 - 1 - 1
<u>N</u>	d 2 sh th and th and traur		19a. Informant's Name/Relationship (Type. Print)  Carmen Dixon-Hodge- Daughter Washington, D.C.			n, State, Zij	o Coae)
	s 1 an f Heal item 2 other			20020 Date	20c. Location	- City or T	own, State
altimore,	Page nent o nt: If		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Riverdale Pk Crem 07-3	11-08	Rivero	dale.	MD
a I	rmit. spartn porta y Inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility				
<u> </u>	9 9 5 6 9		1813 Potomac Ave	e.,SE;	wasn.	., DC	
**			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory a	arrest,		Approximate Interval Between Onset and Death
6	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Arksidsclassic Heart Disease				
	Examiner		Due to (or as a consequence of):				
100	- N	Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c				
Ö,	ie exe		resulting in death) Last  Due to (or as a consequence of):				
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical	d			-	
	certifi Iding	/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy		234 [	Date of deliv	env
Box	The law requires that the death certive has been signed by the attending age 2 should be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   1			Month	Day Year
P.0	w requires that the de been signed by the should be detached	hys	9 ☐ Unknown				
	es tha gned be de	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did			he cause of death?
ord	requir een si nould			1	Yes 2 No	3 □ Pro	bably 4 □Unknown
Records,	has by	Completed		24a. Was	DSV	prior to co	opsy findings available ompletion of cause of
/ita	sician; The certificate h		OF West and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the st		ormed? 2 No	death? 1 ☐ Yes	2□ No
	ysicial is certii directo	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No   Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA   Other: 4 ☐ Nursing Ho			thar (Casa	
0	g Phy er this eral c	- 1	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		how injury occ		(y)
0	ending Fath.	atio	2 Accident investigation M 1 Yes 2 No				
Division or	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (	(Street and Nur wn, State)	mber or Rur	al Route Number,
	Hospital or Atten 44 hours after death Funeral Director: tely filled in by the		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the	onuco(o) and	mannaras	stated
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the line, date and place, one)  and manner stated.				
	To the Hospital or Attending Physician: within 24 hours dired death. To the Furneral Director: After this certifics completely filled in by the funeral director; it	Me	29b. Signature and title of certifier 29c. License number	T	29d. Date sign	ned (Month,	Day, Year)
	6		D3CZO6		Jula		Zws
2	_ ( )		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  William T. Tannel and 11701 Wright Rond	CL	, JADIL	16-0	
1	C		31. Date filed (Month, Day, Year)  32. Registrar's Signature	. thr	WAR KI	my ou	mollena
	Sta Registr		JUL 0 9 2008				

State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar					cate of				F	Reg. No.	~	0 0	0 23	1 3
Physici		Decedent's Name (First, Midd Jesse		sse J James		Eme		Emrick mrick		2	2. Date of Dea Month	ath Day	Year		3. Time of Death	1
Medical Exam	lner	4a. Facility Name (if not institution								-(Pasti	July 18, 2	2008			1725 hrs	
		Western Maryland He			iber)		41	b. City, Town, o Cumberlai		of Death			:. County of <b>\llegany</b>	Death		
Funeral		Social Security Number	6. Sex		7. Age (In y	rs. last bi	irthday)	If Under 1 Ye		er 24Hrs.	8. Date of B			g. Birth	nplace (State or F	Foreign
Director		180-62-7227	1 XM	2 F	26		Yrs.	Months Da	_		02/18	•	1	Cou	ntry) nnsvlvar	
		Usual Residence of Decedent	124				- 110.				1.02/1	3/13	02	10	IIIby I vai	IIa
v any		10a. State 10b. County			10c.	City, Tow	n or Locatio	n					-		10d. Inside City I	
S Maryland or 28a-f show fled at once.	ō		egany				Cum	nberlan	d						1 X Yes 2	No
Maryl 28a-1	Director	10e. Street and Number	Q.					10f. Zip Code				10g. Citi	zen of Wha		try?	
215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.		303 Pulaski	Stree	et				21	502				US	A		
th will rems 2	Funeral	11. Marital Status  1 X Never Married 2 M		Was Dece Armed For	dent Ever	in U.S.		Decedent of H s, specify Cuba				0-	14. Race - White,		an Indian, Black,	
er dea			orced If Yes,	Yes Give Year	2 X N	10		Yes 2 X N			. ,				1. 1.6.	
urs afl tural'	d by	15. Decedent's Education (Spe	or Da	tes:	complete	d) 16a		s Usual Occup			rk done	116b. h	Specify: Kind of Busi		hite	
72 ho n "na al Ex	etec	Elementary/Secondary (0-12)		ollege (1-4			during mos	st of working li	e. DO NOT	use retire						
036 Atthin ene.	Completed	12	l				Dr	ywall	Hange	r			Cons	tru	ction	
15-0 Filed v Hygi d oth		17. Father's Name (First, Middle								,	First, Middle,					
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	James  19a. Informant's Name/Relations		Mauri	.ce	La	Emri			anna		Ly			Bisick	
MD 2 id 2 shou lith and N m 27 is n aumatic	ပ	Dianna Lynn Ry		,	r			Address (Str gh Lin							Zip Code)	
	-	20a. Method of Disposition				0b. Place	of Disposit	ion (Name of c		· .	Date				Town, State	
Baltimore, permit. Pages I ar Department of Hee Important: If itel		1 X Burial 2 Cremation		moval from		crema Cer	atory or other	r place) IIe				, ,				
nit. Partme		4 Donation 5 Other S 21. Signature of Funeral Service				rello	OWShir 22. Na	Cemet	ery ss of Facilit	V Adam	22/2000	5 C	enter	vil	le, PA Home, P.	Δ
ii ii De M		40100 St	(00	lar	~	_/		4 Deca								• 11 •
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complication	ns that cau	sed the de	eath. Do r	not enter the	mode of dying	, such as	cardiac or i	espiratory ar	rest, sho	ock, or hear	t	Approximate In Between Onse	
/Medical xaminer		Immediate Cause (Final disease			ic (n	norph	ine &	metha	lone)	into	xicati	on a	<u>S</u> .		Death	st and
÷-		or condition resulting in death)	Due to	(or as a c	onsequen	ce of): C	ocain	e use								
	ē	Sequentially list conditions, if any, leading to immediate	Due to	(or as a c	onsequen	ce of):								-		
	ıminer	cause. Enter Underlying Cause (Disease or injury that initiated	c													
17 mg 1 mg	Exa	events resulting in death) Last	Due to	(or as a c	onsequen	ce of):										
760, cate be execut physician and he burial - tra	n/Medical	X UNPENDED	X AME	NDED 3	3a,27	,28a	-f, p	erME 9/11/d	882	8/26/	08 TT	#1 j	per M	E		
760, icate be physic the burn	Med	IF FEMALE:	23c		tcome of			9/11/0	8 11				d. Date of d			
687 ertific	ian/	23b. Was decedent pregnant in the past 12 months?	1 _	Live birt	th		2 Feta	I death 3	Ectopi	c pregnan	су		Month		ay Yea	ir
Sox leath c e atten for us	Physicia	1 Yes 2 No 9 Uni	nown 4	Unknow	nt at time o	or death	5 Othe	er (Specify)								
P.O. Box 68 that the death certi med by the attendin etetached for use as		Part II. Other significant condit				not resultin	ng in the un	derlying cause	given in P	art I.	23e. Did t	obacco	use contrib	ute to t	he cause of deat	h?
ords, P.C. w requires that as been signed to should be deta	d by										1Ye	s 2 🗸	No 3	Proba	ably 4 Unkn	nwor
rds requi	Completed	(	_								24a. Was				opsy findings ava	
e co te has ge 2 s	Ĕ						***					ormed?	de	ath?	ompletion of caus	
ital Reco ician: The law s certificate has		25. Was case referred to medica						26.Plac	e of Death	(Check on	1 Yes	2N	0 1	✓ Yes	2 N	No
Vita ysicia his ce direct	To Be	examiner?	Hospita	!: 1 Inp	patient 2	✓ ER/C	Outpatient		Other 4		Home 5	Reside	nce 6	Other:		
ing Ph	أيّا	27. Manner of Death	28	a. Date of (Month, D	Injury	28b.	Time of Inju	ury 28c. Inj	ury at Worl	2</th <th>8d. Describe</th> <th>how inju</th> <th>игу оссигге</th> <th>d</th> <th></th> <th></th>	8d. Describe	how inju	игу оссигге	d		
ion tendii eath. for: /	ig	1 Natural 5 Pend 2 Accident Inves	:	/18/		un	k	1	Yes 2	No	unk					
or At after d Direct in by	ertification:	3 Suicide 6 X Coul	d not be	Be. Place	of Injury - A		farm, street,	factory, office	building, e		8f. Location (	Street a	nd Number	or Rur	al Route Number	r, City
Spital spital nours a neral I		4 Homicide	mined (S	Specify)	поше	: 				1	Cumber	Tanc	i, mb	Lac	ski St.	
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funceral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	g	29a. Certifier 1 Certifying Pt (Check only one) Medical Example 1	nysician: To	the best of	of my know	vledge, de	eath occurre	d at the time, on, in my opinion	ate and plant	ace, and d	ue to the cau	se(s) an	d manner a	s state	d.	
To t with To t	Medical	29b. Signature and title of certifie	and m	anner stat	ted.	JII 4110/01			se number	curred at t	vale				th, Day, Year)	
		/ 6 .	0.	. 1					M.E.				19, 200		II, Day, rear	
	1	30. Name and address of person	who comple	led called	of death /	Item 22a)							.0, 200			
		Laron Locko MD A	opiotont A		,		1 Penn S	Street, Balti	more, N	ID 2120	1					
St	ate	31. Date filed (Month, Day, Year)	nnn	3. Regi	strar's Sig	nature	1									
Regist	rar	JUL 23 2	שעט	All	Sal A	15	mark	P								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27, 28a-f per man 9882,08/08/08dhb 200 8 23759 Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Year Foreman 11:29PM Koland une 30 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Manyland Medical Center Balhmore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Days Hours Min 216-14-2874 Director 88 MARYLAND APR 1,1920 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Its Mydical Experient must be notified at 10c. City. Town or Location Director X Yes 2 □ No MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 FEDERAL ST., APT 78 21601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XT Yes 2 ☐ No If Yes, Give Ye ar or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: by Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DEPUTY SHERIFF LAW ENFORCEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CLIFFORD FRANKLIN FOREMAN MABEL FLORENCE JOSEPH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANICE F. ABBOTT/DAUGHTER 8259 LAUREL LANE, DENTON, MARYLAND 21629 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages ' 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY 7/7/2008 HURLOCK, MARYLAND 21. Signature of Funeral Service Licensee Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** (ardiomyopam) disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER physician and s the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed b be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Spine Frachure Thoracic 1 Maryes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 certificate l performed 1 □ Yes 2 No 2 No Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) aminer? Hospital: 1X Yes 2 10/10 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manper of Death 28d. Describe how injury occurred After or Attending Injury 5 ☐ Pending investigation John of hours after death.

uneral Director: Af 2X Accident Unknown Unknown M 1 ☐ Yes 2 No Multiple falls 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Unknown Unknown To the Hospital
within 24 hours a
To the Funeral C
completely filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P18559

Registrar

RK

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State

meena

31. Date filed (Month) Dif.

Shah MD

Ye 0 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

gistrar's Sign*a*ture

22 South Greene Street Baltimore MD 21201

une 30 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 10:25 aM Fannie Emma Fortuna aka Eufamia Fortuna July 8 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 24□ F Director 339-16-2678 June 19. 1918 Wisconsin Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, The Modical Expression is that be motified at District of 1 Yes 2 No Director Columbia Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 6417 31st Place, Funeral 20015 12. Was Decedent Ever in U.S. Armed Forces? 1 KYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married WWII If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: White Specify ≥ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) s and Mental Hygiene. Is marked other than Registered Nurse Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter Fortuna Elvira Lencioni 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Francis Dicello/Nephew 6417 31st Place, NW, Washington, DC 20015 Health a permit. Pages 1 and 2 Department of Health Important: If Item 27 any Injury or other tra once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State July Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd,. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or com, lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MY OF ARDIAL INFARCTION Physician DAY disease or condition resulting in death) /Medical THENUSCIENONC CANDIONS WAR DUBBE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2☐No 3☐ Probably 4☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

Records, of Vital Division

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Baltimore, Maryland 21215-0036

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUL

32 Registrar's Signature

AMENVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 9 2008

29c. License number D 5 3 3 6 7

:117 SINGREBRING MD:

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Juk JOHN HENRY FORD, SR. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Plata Medical If Under 24 Hrs. 8. Date of Birth Month, Day, MAY 27, 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year Days 1935 Months 1 □ M 2 □ F MARYLAND 73 214-30-1029 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 No LA PLATA MARYLAND CHARLES 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 20646 10929 LA PLATA ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 X No Specify: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 9TH GRADE (0-12) College (1-4or 5+) BUILDING SERVICE WORKER EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOSEPHINE HENRIETTA (HOLLY) FORD FRANCIS FORD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10929 LA PLATA ROAD, LA PLATA, MARYLAND FRANCES C. FORD / WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. JOSEPH'S CHURCH CEMETERY JULY 12,2008 POMFRET, MARYLAND 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 Signature of Fundial Service Licensee PADIA C. THORNTON JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardio Kesa disease or condition resulting in death) Due to (or as a consequence of oronary if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sequence of): as a consequence of) 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Diabe 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

**Physician** /Medical Examiner

physician

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certificate has page 2

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To the Hospital within 24 hours a To the Funeral L

funeral director,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Exyminar must be notified at

Baltimore, Maryland 21215-0036

Box 68760,

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Division of Vital Records,

Pages

Examiner the burial-tran Physician/Medical use as ō detached s been signed by should be detact

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Completed

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Be 1 Yes 2 No Certification: To

5 ☐ Pending investigation

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

MUCO

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CENNA MEDICAL CENTER 7-C POST OFFICE RD. WALDONF, MD. 20602 ABBAS A. OMAIS, M.D. 31. Date filed (Month, Day, Year)

State Registrar

JUL 0 9 2008 32. Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend PI line a-c MPII per MD C882 8/5/08 TT Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 28 2008 PATRICIA D. GUSCHKE JUNE 11:12PM<sup>M</sup> /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner TALBOT HOSPICE HOUSE EASTON TALBOT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Months Days Hours 414-52-2537 Director 80 MAR 17,1928 MARYLAND Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2X No Director TALBOT ST. MICHAELS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7652 PEA NECK ROAD 21663 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No Specify: Specify: WHITE \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 Is marked other this any Injury or other traumatic event, the once. ADMINISTRATIVE DIETITIAN HEALTH CARE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CLIFFORD C. DAUGHERTY EMMA COX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7652 PEA NECK ROAD, ST. MICHAELS, MD 21663 JOSEPH E. GUSCHKE /Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PARK 7/5/2008 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 MERCERDA JOHNR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Myocardial infarction**Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cus /Medical Due to (or as a consequence of): Profound anemia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Intrabdominal Malignancy presumed to be ovarian Due to (or as a consequence of): primary Division or Vital Records, P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 □ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 12 Mccca 1 les 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Cerebovascular accident 24a. Was an autopsy performed? Ves 2 No Chronic obstructive pulmonary disease 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ۴ this 27. Mannet of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendition within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

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State Registrar 31. Date filed (Month, Day, Year)

JUL 0 2 2008

30. Name and addr.

32. Registrar's Signature

e of death (Item 23a) (Type, Print)

55 Cynwood Dr. Easton und 21601

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1 - For State Registrar 23763 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 4:07 pM DURETHA GAREY 2008 04 July /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 1520 Foster Road Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs . Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Funeral Months Days Hours 1 ☐ M 2 🗷 F District of Columbia 69 March 4, 1939 Director 213-42-5520 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the "Marical Examinar mart be natified at agnee. 10d. Inside City Limits 10a, State 10b County 10c. City. Town or Location 1 ☐ Yes 2 X No Director Montgomery Silver Spring Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20905 1520 Foster Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify Specify: ≥ 3 Widowed 4 Divorced **Black** Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 11 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Elizabeth Dorsey Brainard Hyson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1520 Foster Road, Silver Spring, Maryland 20905 Thomas Garey - Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 07/09/2008 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Ola 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner mystrol Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 XNo 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours a er death.

To the Funeral Director: A completely filled in by the fu 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.CAROLINE ST. HRY 601 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 09 JUL Registrar

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Box 68760, a death certificate be the attending physici ed for use as the buri	1 1		known 4	Pregnant	at time of de	eath 5 Oth	ner (Spec	ify)				1				
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Division of Vital Records, P.O. B ral or Attending Physician: The law requires that the data of a star death.  The law requires that the data of the led in by the funeral director, page 2 should be detached the start of the relations.	<u>}</u>	-		· ·		-					1 Ye	es 2	<b>/</b> No 3 _	Probat	oly 4 U	inknown
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ing Phy After th funeral	27.	Manner of Death	2	8a. Date of Ir	njury v.Year)	28b. Time of I	njury 2	8c. Injury	y at Work?				jury occurred object co			
Sion Mtendi death. cctor: /			ding stigation	Jul 6, 2008		0250 hrs		1Y	es 2 🗸 N	10	onver date	IIXCG	ODJCCI CO	1131011		
ivision or Attend after death. Director:	2 2 3 4 2 2 3 4 2 3 6 4 7 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6	Suicide 6 Cou	ld not be	28e. Place of	Injury - At h	ome, farm, stree	et, factory,	office bu	uilding, etc.	- 1	or Town,	State)	and Number			-
Divis  To the Hospital or A within 24 hours after to the Funeral Dire completely filled in b	4 202	Homicide		(Specify) L						- 1			Olney Mill F			
To the Howithin 24 h	(Che one,	eck only Certifying P	hysician: T miner:On t	o the best of ne basis of ex	my knowled xamination a	lge, death occur and/or investigat	red at the ion, in my	time, dat opinion,	te and place death occu	e, and c urred at	the to the cau	use(s) a e and pl	nd manner as ace, and due	stated to the	cause(s)	
To the within 2 To the complete	29b	. Signature and title of certifi	and	manner state	d.				number				Date signed			)
3		1.111	Ola	6	M	D		O.C.N					y 6, 2008		-	
	30	Name and address of person	who compl	eted cause o		,						ــــــــــــــــــــــــــــــــــــــ				
		Russell Alexander Mi		stant Med			Penn S	Street,	Baltimor	e, MD	21201					
Sta	e <sup>31.</sup>	Date filed (Month, Day, Year)	2008	Eda	trar's Signat	ure	M. a					001	ME			
Registra	ar	טטב עַיּאַ	2000	KURLU	4 14	A A THE						UUI	AIE.			

Physician	
/Medical	
Examiner	

1 - For State Registrar

	Physicia		Eudosia	,		ia de	Gutie	rrez		Month July	7, 20	Year 008	8:38 a <sup>M</sup>
	/Medic Examin		4a. Facility Name (I.	f not institution	, give street and number)			4b. City, Town, or	Location of De			County of Death	
	_xa		Shady Gr	ove Ad	ventist Hosp	oital		Rockvil	.le		Mor	ntgomery	
	Funeral		5. Social Security N	umber		je (In yrs. la	st birthday)	If Under 1 Year Months Days		in. 8. Date of B	irth lay, Yea <i>r)</i>	9. Birthp Coun	place (State or Foreign atry)
	Director	j	215-37-4		1 □ M 2 😿 F	6	1 Yrs.			March		947 Pe:	ru
	p s		Usual Residence of 10a. State	Decedent 10b. County		10c City	Town or Lo	cation				1	0d. Inside City Limits
	sho	ō		100. County									1 ☐ Yes 2 No
	he M	Director	Maryland  10e. Street and Nur		Montgomery	N	orth	Potomac 10f. Zip Code			10g. Citiz	zen of What Coun	itry?
	with 1				Count			20878	,			USA	
	eath	Funeral	15307 K	wanzan	12. Was Decedent	Ever in U.S	. 13.			(Specify Yes or N	0- 1	4. Race - Americ	an Indian,
	fter d r item	ᇤ	1 Never Marri	ied 2 🔀 Marri	Armed Forces? ed 1 ☐ Yes 2 €	•		Was Decedent of H If Yes, specify Cuba				Black, White, 6	
3	be fled within 72 hours after death with the Maryland Hygiene.  ad other than "natural", or items 23a or 28a-f show event, I're Model Evaning must be notified at	þ	3 🗌 Widowed		If Yes, Give Year or Dates:		1	1 LaryYes 2 □ No	Specify:	Peruvian		Specify: Wh	ite
	'2 ho	Completed	(Spec	15. Decedent	's Education t grade completed)		16a. Dece	dent's Usual Occup	ation	vorkina	16b. Kir	nd of Business/Ind	dustry
7	thin 7	ם	Elementary/Seco		College (1-4or	5+)	life.	DO NOT use retired	j)		1		
4	ed wi ygier yer th	ပ္ပြဲ	12		1			Homemaker		/Final Middle	. 44-1-4	Own Home	e
2	e d tal	Be	17. Father's Name Eustagu							Name <i>(First, Middl</i> ia Balare		ourname)	
y	2 should be filed withi and Mental Hygiene. is marked other than aumatic event, the M	ပ္								3.		Town State 7in	Codel
	12 sh thang 7 is n traun	10	19a. Informant's Na					ng Address (Street					
ב ט	ss 1 and 2 should of Health and Mer item 27 is marke r other traumatic	1	20a. Method of Dis		ez/Daughter	20b. Pli	ace of Dispo	07 Kwanza sition (Name of		Date Date		cation - City or To	
2	Pages nent of I		1. ☐ Burial 2 i	☐ Cremation	3 Removal from State	ce	metery, crei	natory or other place donado Ceme		July 13,			
	ait. Pa artme artani ortani injury		4 ☐ Donation  21. Signature of Fu							2008			ios, Peru
ם מ	permit. Pages Department of Important: If i any injury or o	1 1/2		chen	20,00			2. Name and Addre rancis J.					MD 20001
-					complications that cause	d the death	. Do not en	ter the mode of dyir	ng, such as care	diac or respiratory	arrest,	er sprin	<ul> <li>MD 20901</li> <li>Approximate Interval Between</li> </ul>
	Physician	i v	Immediate Cause	(Final									Onset and Death
1	/Medical		disease or condition resulting in death)	on	a. Septic Due to (or as								
	Examiner				b. Urinary			ection					
	D +	ner	Sequentially list co if any, leading to im cause. Enter Under Cause (Disease or	nditions, nmediate	Due to (or as	a consequ	ence of):						
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5	e exe		resulting in death)	Last	Due to (or as	a consequ	ence of):						
	ate b	dica			d			<del></del>					
o :	death certificate be executed e attending physician and d for use as the burial-transit	sician/Medical	IF FEMALE:		23c. If yes, outcome	of pregnar	nev	7.7				and Data of delive	- CHARLES
	attend attend for us	jan	23b. Was deceden in the past 12	t pregnant months?	1 Live birth	2 🗀 Fetal	death 3[	☐ Ectopic pregnand			1	23d. Date of delive Month	ery Day Year
		ysic	1 ☐ Yes 2 [ 9 ☐ Unknown		9 Unknown		auii 5L	Other (specify) _					
	w requires that the disbern signed by the should be detached	Phys	Part II. Other signi	ficant condition	ons contributing to death	but not resu	Iting in the u	inderlying cause giv	en in Part I.	23e. Dio	l tobacco u	se contribute to t	he cause of death?
2	uires sign Id be	d by								1 🗆	Yes 2	¶No 3☐ Prol	bably 4 Unknown
5	v req beer shoul	Completed								24a. Wa	ıs an	24b. Were auto	opsy findings available
ב ב	2 2 2	du								aut	opsy formed?	death?	opsy findings available ompletion of cause of
5	sician; The certificate rector, pag	CC	25. Was case refer	red to medical					26 Place of	1 ☐ Ye s Death (Check onl)	2 <b>X</b> No	1 □ Yes	2 LINO
>	iysicia iis cert directe	Ö	examiner?		Hospital:	ient 2□l	ER/Outpatie	nt 3 □ DOA Oth	er:	ng Home 5 ☐ Re	•	5 ∏Other (Speci	fv)
5	g Phy er this eral o	Ě	27. Manner of Deat	th	28a. Date of Inj	ury	28b. Time o			28d. Describ			
5	nding F tth. r: After e funera	읉	MXNatural 2 ☐ Accident	5 ☐ Pendin investig		ay, rear)	Injury		Yes 2 ☐ No				
2	I or Attendi after death. Director: ≠ d in by the fu	ertification: T	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could r determ	ined   Zoe. Flace of II	jury - At ho	me, farm, st	reet, factory, office		28f. Location City or 7	(Street an	d Number or Run	al Route Number,
5	tal or	Cert	. E 7 Ionniodo										
	To the Hospital or Attending Physician: The law requires that the within 24 hours atter death.  To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	edical	29a. Certifier (Check only	1⊠ Certifyir 2□ Medical	g Physician: To the bes Examîner: On the basis	t of my know of examinat	wledge, dea tion and/or it	th occurred at the tinvestigation, in my	me, date and popinion, death o	lace, and due to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the	ne cause(s) e, date and	) and manner as a place, and due t	stated. to the cause(s)
	To the Hawithin 24 within 24 To the Fu	Medi	one)		and manner s						1	te signed (Month,	
	<b>2</b> × 100 Co	Σ	29b. Signature and	. )		4)	) k	29c. Licens			Zad. Dai	is signed (World),	2000
	0		IMC	kon to	Jonu 1	-,	m	D64	1413			14,/	0008

State

Registrar

9901 Medical Center Drive, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Juanita L. Smith, MD

JUL Q 9 2008

31. Date filed (Month, Day, Year)

		ŀ	1 - For State Registrar	State of Ma	•	epartment Certificate	of Health and of Death		Reg. No.	2008	23	166
	Physici	an	1. Decedent's Name (First, Middle, Las	it)				2. Date of De Month	Day		3. Time of	
	/Medic		Betty W. Garner						5/200		2:35	P M
7	Examin	er	4a. Facility Name (If not institution, give				own, or Location of De	eath		County of Deat		
	Eupoval		42 South Paulton 5. Social Security Number 6. S		e (In yrs. last birtl	nday) If Under 1			th	nne Aru	hplace (State ountry)	or Foreign
	Funeral Director			□M 2⊠F	77 Y	rs. Months	Days Hours M	in. (Month, Da 4/14/1			u <i>nt</i> ry) n <b>i</b> ngton	
	Pu ,		Usual Residence of Decedent		10a City Town	as I continu					10d. Inside C	
	ehow	5	10a. State 10b. County		10c. City, Town							2 No
	the M	ecto	MD Anne Aru	ndel	Laure]	L 10f. Zip C	2ode		10g Citiz	zen of What Co	untry?	
	with Ba or	<u>a</u>	42 South Paulton	S+			20724			U.S.A.	,	
	death ms 2:	Funeral Director	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. Was Decede	nt of Hispanic Origin? y Cuban, Mexican, Pu	(Specify Yes or No	0- 1	14. Race - Ame		
9	or its	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	10	1 ☐ Yes 2		ieno rican, etc.)	ļ	Black, Whit Specify:	e, etc.	
9	72 hours after death with the Marylan "neturel", or items 23s or 28s-f ehow offel Examinat must be notified at	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:							White	
21215-0036	within 72 hours after death with the Maryland ane. sne. then "neturel", or items 23s or 28s-f show the Mcdigal Examiner must be notilised.	Completed	15. Decedent's Ed (Specify only highest gra			Decedent's Usual (Give kind of work life. DO NOT use	done during most of a	working	16b. Kir	nd of Business	Industry	
12	withii iene. then	ошр	Elementary/Secondary (0-12)	College (1-4or 5	i+)	redit Spe			Cre	edit Bu	reau	
	illed I Hyg othe	BeC	17. Father's Name (First, Middle, Last)					Name (First, Middle				
/lar	uld by Menta Venta Virked	To E	Charles Weeks				Nanni	e Viola M	iu11			
Maryland	2 sho and I te ma		19a. Informant's Name/Relationship (				Street and Number or		_			
	and tealth m 27		Timothy Dixon, Ne	phew		L4 Sunnyb Disposition (Name	rooke Dr.	, Glen Bu		MD 21 cation - City or		
100	in the or of or of		20a. Method of Disposition 1 🖾 Burial 2 ☐ Cremation 3 ☐		cemetery	v, crematory or oth	er place)					
Baltimore,	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. importent: If Item 27 is marked other then eny injury or other traumatic event, Ite Magnes.		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer	1	Cedar	Hill Cem	etery 7/ Address of Facility	11/2008		tland, 39 Balt		 \
Ba	Department of the partment of		21 Par t	- M	1.1		Funeral H	ome. P.A.		attsvil		
			23a. Part1. Enter the disease, or com	plications that caused	the death. Do n						Approxima Interval Be	te
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition			Cardio	ascular D	iceace			Onset and	Death
	/Medical		resulting in death)	u	a consequence of		abcarar b.	<u> </u>				
	Examiner		Sequentially list conditions,	<sub>b.</sub> Hyperte							20 Ye	ars
	pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence o	f):						
	xecut and	xan	that initiated events resulting in death) Last	cDue to (or as	a consequence o	of):						
760,	ate be executed hysicien and the burial-transit	calE		d								
68	certificat Iding phy Ise as the	_										
Box	ires thet the death certifica signed by the attending ph d be detached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pre			2	23d. Date of de Month		Year
	ne death the the the the the the the the the t	/sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 🗌 Other (spe	city)		-		,	
P.0	requires thet the een signed by th nould be detache	Ph	Part II. Other significant conditions of	ontributing to death b	ut not resulting in	the underlying car	use given in Part I.	23e. Did	tobacco u	se contribute to	the cause of	death?
Records,	uires r sign ld be	d b	Obesity					1 🗆	Yes 2	No 3□P	robably 4 🗆	Unknown
Ö	- 0 70	lete	Hyper Lipidemia					24a. Was		24b. Were a	utopsy findings	available
	0 - 0	mo	11) por 112 product						opsy ormed? 2 \Bo	prior to death?	completion of	cause of
ita	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of	Death (Check only				
>	Physician: this certific ral director,	To	1 ☐ Yes 2 🔯 No	Hospital:		patient 3 DOA		g Home 5 ⊠ Res			ocify)	
Division of Vital	nding Physath. r: Atter this is tuneral dir	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. T y Year) Ir		c. Injury at Work?	28d. Describe	how injur	y occurred		
isio	death death ctor: / the	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b		ury - At home fai	m, street, factory,	1 Yes 2 No	28f. Location	(Street an	d Number or R	ural Route Nur	n <i>ber</i> .
Θ	atter Direction by	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)	m, stroot, rabidly,	omoo		wn, State			
	To the Hospital or Attanowithin 24 hours after death To the Funerel Director:	alC		ysician: To the best								
	the Ho nin 24 the Fu	ledical	one)	niner: On the basis o and manner st				ccurred at the time				s)
	With To t	Σ	29b. Signature and title of certifier	remu	lu	29c.	License number		29d. Dat	e signed (Mon	th, Day, Year)	
	(5)		1 000	1			13671		Ju1y	7, 20	08	
	JE		30. Name and address of person who Bachubhai Manejw				#1∩2 T	aurel Mo	2070	17		
	Str	ate	31. Data filed (Menth )(1) (Year)	32. Rustr	ar's minute	alk DI.	9 1/1UZ9 La	aurer, PD	2070	<i>)</i> /		

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** William Goletz July 7, 2008 11:00 P <sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent Center Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) 4/12/1934 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 1 M M 2 □ F 74 Director 467-62-9876 Hungary Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Anne Arundel Crofton 1 ☐ Yes 2 X No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21114 USA 1756 Copley Court death ! Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗷 No 'natural", or Maryland 21215-0036 Specify. Specify: ρ White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Electrician Union traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown Goletz ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Holly Elaine Keenan/Daughter 2103 Higher Court Crofton MD 21114 item 27 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of F Important: If ite any Injury or otl 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 7/9/2008 Alexandria, Virginia Metropolitan Crem. 21. Signature\_of Funeral Service Licenses 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician otic Heart Athenosc ears disease or condition resulting in death) /Medical Examiner Dement Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): .O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 sl autopsy perform 1☐ Yes 2 1 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation 1 Natural after death.

Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours at TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year)

Registrar

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 2008

D20108

14300GALLANT FOXIN, BOWLE MD20715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23768 Certificate of Death Reg. No. 2 0 0 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:10 PM Thomas P. Graham July 8, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery County If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year Hours Months Days 1 **X** M 2 □ F 84 218-12-5659 12/29/1923 Director New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ms 23a or 28a-f shor must be notified at Director 1 ☐ Yes 2 X No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20716 items 23a 3800 Enfield Chase Court Apt. 312 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married ō 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural", the Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Management Sears Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental Thomas J. Graham Ila Banning 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important: If item 27 Is any injury or other tratonce. 3800 Enfield Chase Court Apt. 312 Bowie MD 20716 Hazel R. Reeves 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 7/14/2008 | Brentwood, Maryland 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licenses 6512 NW Crain Hwy. Bowie MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gastesointestinal **Physician** bleeding disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner disease asi Sonaly Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached t 9□Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Manger of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 Accident Year) (Month, Day Injury 1 ☐ Yes 2 ☐ No hours after death uneral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number

mpletely State Registrar

31. Date filed (Month, L

OINTI

29b. Signature and title of certifier

Registrar's Signature

Potel Leyonti

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0052586

29d. Date signed (Month, Day, Year)

		For State Registrar	State	of Marylan		artment of F rtificate of I	lealth and N Death	∕lental Hyg ¤	iene eg. No. 20	08	23769
Physi	ician	1. Decedent's Name (First, Middle,	,		-			2. Date of Deat	Day	Year	3. Time of Death
/Me	dical	Barbara Ann Guy  4a. Facility Name (If not institution,		umbor)		4h City Town or	Location of Death	July	4c. County	008	846PM
Exam	niner	Doctors Communit	-			Lanham	Location of Death		Prince		ge's
Funer			5. Sex 1 □ M 2 X F	7. Age (In yrs. 66	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 6/8/194	Year)	Count	ace (State or Foreign fry) Sylvania
		Usual Residence of Decedent						0/0/1/	2		od. Inside City Limits
f shov	P	MD Prince	e George		ty, Town or Loc Bowie					10	1 MYes 2 □ No
the N	Director	10e. Street and Number	George	5	DOMIE	10f. Zip Code		1	0g. Citizen of	What Count	гу?
th with 23a or	al D	12106 Fern Lane	9			20715			USA		
er dea	Funeral	11. Marital Status	Armed F		S. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - America ck, White, e	
J36 irs afte	S F	1 ☐ Never Married 2 ☐ Marrie  3 ▼ Widowed 4 ☐ Divorced	d 1 □ Yes If Yes, G Year or	2 ₹No live Dates:	1	□Yes 2 No	Specify:		Specif	y: Wh	nite
21215-0036  J within 72 hours aff giene.  If than "natural", or  The Medical Exercision	Completed	15. Decedent's (Specify only highest	Education	n	16a. Deced	lent's Usual Occup	ation	ina	16b. Kind of B	usiness/Indi	ustry
727 vithin sne. than "	Jan Jan	Elementary/Secondary (0-12)	· ·	(1-4or 5+)			during most of work f)		Orm Hor	~~	
ert,	l o	12 17. Father's Name (First, Middle, La	ast)		HOIII	<u>emaker</u>	18. Mother's Name		Own Hor		
Taryland 2 should be file and Mental Hy Is marked oth	75 B	John Sheffer					Paulin	e Leathe	ery		
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any lnjury or other traumatic ex	1	19a. Informant's Name/Relationshi				•	and Number or Rui			, State, Zip	Code)
Te, I 1 and Healt tem 27		Denise M. Lucas,	Daugnte.			SPITAL Lo sition (Name of natory or other place	ane Bowie		20c. Location	- City or Tov	wn, State
altimore, mit. Pages 1 ar partment of Hes portant: If item y Injury or othe		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Qther (Spe		State			dens 7/12	/2008	Davidso	onvill	e MD
anti.	ģ	21. Signature of Finer / Service Li		Lan		. Name and Addre		all Fune			
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		23a. Part 1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final	omplications that my one cause on	caused the deat each line.	h. Do not ente	er the mode of dyir	ig, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
Physicia /Medica		disease or condition resulting in death)	a	(or as a conseq		1 a					
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ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a conseq	uence of):						
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BOX leath ce attendir	cian/	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregna birth 2□Feta gnant at time of o	l death 3 □	Ectopic pregnance Other (specify)	у			ate of deliver onth	ry Day Year
VISION OF VITAIL RECORDS, P.O. BOX Of Attending Physician: The law requires that the death certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 🙈 No 9 ☐ Unknown	9 ☐ Unk					-4			
S, restha		Part II. Other significant condition	1		ulting in the un	iderlying cause give	en in Part I.	23e. Did tol	_		e cause of death?
Hecords,  ne law requires t e has been signe ge 2 should be c	Completed by	cmp	nysz	ma				1 41 24	2 □ No	3 ☐ Proba	
he law e has ige 2 s	Jdw						<u>.</u>	24a. Was a autops	med?	prior to con death?	osy findings available npletion of cause of
VITAI ician: T certificat ector, pa	a)	25. Was case referred to medical					26. Place of Deat			1 □ Yes	2  No
OT V Physic r this ce	TO B	examiner? 1 ☐ Yes 2 ☐ No			ER/Outpatien		er: 4 ☐ Nursing Ho	ome 5 ☐ Reside	ence 6 □Otl	her (Specify	)
Jn C ding P After I funera	ii	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	(Mo	e of Injury nth, Day, Year)	28b. Time of Injury	Worl	yat ⟨? Yes 2 □ No	28d. Describe ho	ow injury occur	red	
VISION Attending er death. rector Afte by the fune	ficat	2 Accident investiga 3 Suicide 6 Could no determin	t be 28e. Plac	e of Injury - At he	pme, farm, stre		res 2 🗆 140	28f. Location (St	treet and Numi	ber or Rural	Route Number,
tal or rs afte al Direction	Certification: To	4 Homicide determin	ou buile	ding, etc. (Specif	<i>'y)</i>			City or Town	n, State)		
LIVISION OI VITA To the Hospital in Attending Physician: within 24 hours after death. to the Funeral Lifrector After this certifical physician by the funeral director,	Medical		xaminer: On the				ne, date and place, pinion, death occur				
To the	₹	29b. Signature and title of certifier				29c. Licens	e number	2	29d. Date signe	ed (Month, E	Day, Year)
(10)	7	Thomas		wv	_		3718		7/8	120	08
Al	1	30. Name and address of person w	ho completed cau	se of death (Item	n 23a) (Type, F	Print)	Lanhan	MD 20	0706		
	State	31. Date filed (Month, Day, Year)	32.	Registrar's Signa	iture	,	Lanham,		1		
Regis	strar	JUL 1 0 200	- Bleev	e s	2000						

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 For State Registrar 23770 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 01, 2008 **Physician** Saint Elmo Hillyer, Jr. 17:38 P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges' 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 ☐ F 579-22-9632 84 Director 06/15/1924 Georgia Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director PG Clintan 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ms 23a 6202 Clinton Way 20735 USA Funeral "natural", or items dical Examiner mu Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other than "natural", or ite No. 75 - 57 No. 17 ever Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 2 years Cab Driver Self Employed traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Saint Elmo Hillyer, Sr. ျှ Dora Long 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Englon C. Hillyer - Wife 6202 Clinton Way; Clinton, Maryland 20735 permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran Cemetery 07/11/2008 Cheltenham, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part1. Euter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician Du no (or as a confequence of): disease or condition resulting in death) unknown /Medical Examiner Anoxic unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last encephalogath Exaniner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No performe certificate 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. Ratur Film D43446 7.1.08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) silver spring 9801 Georgea Ave Suit ROINTAN FARAHIFAR M.D 3-32 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUL 1 0 2008

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Colleen M. Horton July 8, 2008 11:12 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George's 8515 Zug Road Bowie If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 F 56 Director 220-56-6761 9/13/1951 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No Director MD Prince George's Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with USA 20720 8515 Zug Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examiner 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No þ White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University Elementary/Secondary (0-12) College (1-4or 5+) of Maryland Payroll 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jack Chaffee Eileen Perry ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7213 Carved Stone Columbia MD 21045 Eric Horton/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Metropolitan Crem. 7/9/2008 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie MD 20715 262 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myocardial 20 min Physician resulting in death) /Medical Examiner Sequentially list conditions, it only had ingle immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Vear 5 Other (specify) signed by the a 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 X Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed this certificate 1□ Yes 2 No Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA 5 KResidence 6 □Other (Specify) 2 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DZ6287 30. Name and address of person who completed cause of death (Item 23a) (Type, Prigit)

Michael Bleach 7305 Baltimon Blvd 107 College Park Mrs 20740 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Lucy Katherine Hiner 2008 July 6, 11:05 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Health Care Charles La Plata If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2X F Oct. 14,1923 Director 226-26-4497 84 Virginia Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. It hand Mental Hyglene. It is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Maryland Charles La Plata Director 10g. Citizen of What Country? 10e. Street end Number 10f, Zip Code 1 Magnolia Drive 20646 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2 💢 No ive 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: White Completed by 3K Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Dept. Store Sales Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Edward Hiner Annie Rebecca Eye မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any injury or other traun Carol Swan / Daughter 6008 Suzanne Road, Waldorf, Maryland 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 7/10/2008 | Monterey, Virginia 4 Donation 5 Dother (Specify) Monterey Cemetery 22. Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME,
211 St. Mary's Ave La Plata, 21. Signature of Euneral Service Licer M01458 Maryland 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** Failure to Thrive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗓 No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed I Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was ...
autopsy
performed?

Ves 2X No has e 2 s certificate has lirector, page 2 or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide To the Hospital 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of coftifier D21031 July 9, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division or Vital Records,

12070 Old Line Center #302

oarle

Waldorf, Maryland

MD

32. Redistrar's Signature

Michael Leatherwood,

JUL 09

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 7:32 A M 2008 Mathew Intner July 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Silver Spring
Under 1 Year If Under 24 Hrs. 3158 Gracefield Road #214 If Under 1 Year Months Days 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Hours 1 X M 2 □ F May 7, Director 83 New York 102-20-2549 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show disal Examiner must be notifled at 1 ☐ Yes 2 TNo Directo MD Prince George's Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with 20904 3158 Gracefield Road #214 U.S.A. Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: ₩₩II 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 12 should be filed www....th and Mental Hygiene.
27 Is marked other than "natural. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Intner Dora Snow 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 is i 3158 Gracefield Road #214 Sheila Intner - Wife Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of I-Important: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Hebron Cemetery 7/8/2008 Flushing, New York 21. Signature of Funeral Service Licensee Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, MD 20852 23a. art1. Enter the disease, or complifictions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician Ventricular Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner sician and burial-transit be executed Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a P.O. 9 Unknown 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, signs d be <u>≨</u> cate has been sig Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy 2 X No 1□ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 XNatural To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a title of certifier July 7, 2008 D24035 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugenia Machado, MD 3110 Gracefield Road Silver Spring, MD 20904 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Lisa Elizabeth Kitchings KOOG /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Prince George's Hospital Cheverly Date of Birth (Month, Day, Year) 2/20/1962 If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min. Months Days 1 □ M 2 🖾 F 46 Washington, D.C. Director 224-13-8689 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director MD Prince George's Hyattsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6 "natural", or items 23a 5122 Kenilworth Avenue #2 20781 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent Ever in 3.3.

Armed Forces?

1 ⊠Yes 2 □ No 1980-1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify If Yes Give Completed by Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White 1992 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) of Health and Mental Hygiene. Communications U.S. Air Force 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ William Ronald DeWitt Elizabeth Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5122 Kenilworth Ave. #2, Hyattsville, MD 20781 John A. Kitchings, Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of I
Important: If Ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 7/9/2008 Alexandria, VA Metropolitan Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. ton 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** IT THOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be execute physician ar the burial-to Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending p IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be rector, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No 2 K No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: (Month, Day, Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No s after death.

I Director: 4
d in by the for 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a filled 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hou To the Fune completely file Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karen Brooks 3001 Hospital Dr., Cheverly, MD 20785 JUL 1 0 2008 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2068 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2 2008 8:50AM M JULY NANCY LEE LAFFERTY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner TALBOT TALBOT HOSPICE HOUSE EASTON If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 T F JULY 21,1941 Director 66 PA 175-32-0261 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Instit if item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Me Real Examiner must be notified at any or other traumatic event, the Me Real Examiner must be notified at 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Director MD TALBOT ST. MICHAELS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9585 MARTINGHAM CIRCLE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2X☐
If Yes, Give
Year or Dates: **X** No 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: 2 Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER 0 OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN HARRIS MARGARET CAMPBELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) KENNETH W. LAFFERTY/HUSBAND 9585 MARTINGHAM CIRCLE, ST. MICHAELS, MD 21663 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 ■ Burial 2 □ Cremation 3 □ Removal from State CRESTLAWN MEMORIAL PARK 7/9/2008 4 Donation 5 ☐ Other (Specify) MARRIOTTSVILLE, MD 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 JOHN MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Immediate Cause (Final lung cancel **Physician** Months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physician ar Division or Vital Records, P.O. Box 68760, Physician/Medical nding I IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 3 □ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 25 No 24a. Was an autopsy performed? Yes 254 No certificate has irector, page 2 1☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6X Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide A 24 hour the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 LAKSHMI VAIDYANATHAN M.D. 219 S. WASHINGTON ST., EASTON, MD 21601 31. Date filed (Month, Day, Year) JUL 0 8 2008 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Willard Roy Larson 5:00 P.M /Medical July 5, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21 Beacon Hill Way Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Davs 1 X M 2 □ F Hours Director 088-24-3634 July 3, 1931 New York Usual Residence of Decedent f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ▼Yes 2 No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 Beacon Hill Way 20878 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2□No 1954-1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify: 3 ☐ Widowed 4 X Divorced 1956 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Systems Analyst Mechanical Engineering Lith and Mental Hv. 7 Is mark 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy Richard Larson ဥ Marion Westa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Ann Main/Daughter 6120 Amy's Terrace, Mount Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 7/12/2008 | Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20888 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive Heart Failure disease or condition resulting in death) Years /Medical Due to (or as a consequence of): Examiner Ischemic Cardiomyopathy Sequentially list conditions, if any, loading to in modate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Years Examiner Due to (or as a consequence of) burial-transi and Due to (or as a consequence of) g physician a pe Physician/Medical attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year ed by the a 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 2 K No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 ☐ Yes 2 No 2 3□ DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) this After 1 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation Injury death. 1 ∏Yes 2 ∏No 2 Accident after death

Director:
d in by the f 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours af

To the Funeral D

completely filled in Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 DMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29b. Signature and ti 29c. License number 29d. Date signed (Month, Dav. Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed Month, Day, Year)

JUL 0 9 2008

Ohn

30. Name and a



s of person who completed cause of death (Item 23a) (Type, Print)



D 19294

		ŀ	State of Maryland / Department of Health an  Certificate of Death	nd Menta	I Hygien	0000	23777
	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Last)  MYONG M. LEE  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of D	Ju.	Ly 7,	2008 Year	3. Time of Death 9:50 A <sup>M</sup>
	Funeral Director		3311 South Leisure World Blvd. #1C Silver Spring  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24	Hrs. 8 Dat	e of Birth onth, Day, Yea	Montgome 9. Birth Cou 941 Kor	ry place (State or Foreign ntry) ea
	the Maryland 28a-f show notified at	ector	Usual Residence of Decedent		100.0	Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 X No
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	3311 South Leisure World Blvd. #1C  20906  11. Marital Status  1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:  1 □ Yes 2 ▼ No Specify:	n? (Specify Ye Puerto Rican,	Un	14. Race - Amen Black, White	tes can Indian,
Maryland 21215-0036	led within 72 hour lygiene. ner than "natural it, the Medical Ex	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  4  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  Business Owner		Ве	Kind of Business/h	
aryland	should be fi and Mental H is marked oth	To Be	Young Joon Kim  Ok Se  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number of	ean Cha	Number, City	or Town, State, Zi	
Baltimore, M	ages 1 and 2 ent of Health it: If item 27 i y or other tra		Young Oh (Daughter) 2959 Saganashkee Lar  20a. Method of Disposition  1 \( \mathbb{I}\) Burial 2 \( \mathbb{C}\) Cremation 3 \( \mathbb{R}\) Removal from State 4 \( \mathbb{D}\) Donation 5 \( \mathbb{D}\) Other (Specify) \( \mathbb{S}\) Use of Disposition (Name of cemetery, crematory or other place) \( \mathbb{N}\) Norbeck Memorial Pk	ne Napo uly 9, 2008	20c.	e, IL 605 Location - City or T ney, MD	
■ Baltin	permit. F Departme Importar any Injur		21. Signature of Funeral Service Literasee 22. Name and Address of Facility 10 east Deer Par	DeVol	Funer Gaithe	al Home	
760,	Physician /Medical Examiner	ical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caused shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ainury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ardiac of respi	ratory arrest,		Approximate Interval Between Onset and Death
P.O. Box 68	the death certifica y the attending pl iched for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □			23d. Date of deli	very Day Year
	equires that en signed b ould be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		e. Did tobacc		the cause of death? bbably 4 ☐ Unknown
al Reco	n; The law r ficate has be or, page 2 sh	Completed by	25. Was case referred to medical 26. Place of	1[	a. Was an autopsy performed?	prior to c death?	topsy findings available ompletion of cause of 2 No
Division or Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the	Certification: To Be	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursi 27. Manner of Death  1 Natural 28a. Date of Injury (Month, Day Year)  28b. Time of Injury Nork?  1 Yes 2 No	28d. De	Residence escribe how in		
Divi	thospital or Al 24 hours after c Funeral Direc stely filled in by	Medical Certifi	29a. Certifier (Check only one)  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	place, and du	e to the cause	e(s) and manner as	stated.
	To the within To the comple	Me	29b. Signature and title of certifier  29c. License number  D54378  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		Ju	Date signed (Month	08
	Sta Registi		Dr. Cheryl Aylesworth M.D. 2730 University BLvd. in 31. Date filed (Month, Day, Year)  32 Registrar's Signature  JUL 0 9 2008	#400 S	ilver S	Spring, M	D 20902

			1 - For Amend Item Registrar		laryland <b>a-f p</b>	d/Depa er me	artment Hillcan	08/6	ealth a 1/08 Death	ind M	,		008	23	778
	Physici	an	Decedent's Name (First, Middle,	,							2. Date of De Month	Day	Year	3. Time of I	Death <b>P</b> M
1	/Medi Examir		WILLIAM EDWIN 4a. Facility Name (If not institution,		·)		4b. City, 1	Town, or	Location of	f Death	JULY	4c. Cou	2008 Inty of Death	7:20	
*	LAGITIT	3	HOSPICE CENTER O	OF QUEEN AN	INE'S			CENT	REVII	LE			QUEEN	ANNE'S	
	Funeral			. Sex 7. A 1 X M 2 ☐ F	ge (In yrs. la	as <i>t birthday)</i> Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Year)	Cou	place (State or ntry)	_
	Director		578–42–7456 Usual Residence of Decedent		73	115.					DECEMBER	26, 193	4 WASH	INGTON,	D.C
	yland how at		10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City	y Limits
	Ba-f s	Director	MARYLAND QUEEL	ANNE'S	S	TEVENS	VILLE							1 ☐ Yes	2 <b>X</b> No
	with the		10e. Street and Number				10f. Zip					10g. Citizen		•	
	leath ns 23 must	Funeral	812 BUCKINGHAI	1 DRIVE 12. Was Deceden	t Ever in U.S	6. 13.	Was Deced		1666	in? (Sp	ecify Yes or No		ITED S		
36	be filed within 72 hours after death with the Maryland hal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 Never Married 2 Married	Armed Forces	? ] No		If Yes, spec 1 ☐ Yes 2	_	n, Mexican Specify:	, Puèrto	ecify Yes or No Rican, etc.)		Black, White	, etc.	
Maryland 21215-0036	hours turai"	ed by	3 Widowed 4 Divorced  15. Decedent's	Year or Dates	1957-1		dent's Usua	l Occupa	ition				f Business/Ir		_
15	iin 72 n "na Medic	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed)	E.\	(Give	kind of wor DO NOT us	k done d	urina most	of work	ring	160. Kille 0	i busilless/ii	iuusiry	
212	d with giene er tha	Completed	12	College (1-4or	5+)	н	JMAN R	ESOU	RCES			FE	DERAL	GOVERNI	MENT
pu	be filed Ital Hygi id other event, t	Be	17. Father's Name (First, Middle, La	,					18. Mother		e (First, Middle		name)		
<u>₹</u>	should be filed and Mental Hygi s marked other umatic event, t	10	WILLIAM C. MAT.  19a. Informant's Name/Relationship			10b Mailie	na Addroop	(Street o	and Mumb a		RA MORR		C4-4- 7:	- 0-4-1	
<u>⊠</u>	s 1 and 2 should f Health and Mer ttem 27 is marke other traumatic		CHARLES MATTHEW:								ral Route Numb <b>HESTER</b> ,			·	
more,	es 1 ar of Hea fitem 2		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·		ace of Dispo	sition (Nam	ne of	1	-	Date		on - City or T	_	
Ē	0 0		1 ☐ Burial 2 <b>X</b> Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		9	SAPEAK			i		LY 8 008	STEVEN	SVILLE	E, MARY	LAND
Balti	permit. Pag Department important: I any Injury o once.		21. Signature of Funeral Service Li	cens			LLOWS O6 SHA	Addres HE MROC	LFENE K ROA	EIN		WNAM F	UNERAL	HOME,	
). }	Physician /Medical Examiner	ier	23a. Part1. En er l disease, or c shock, or hear inc. I is of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	a. Due to (or a	neum s a consequ	onia ence of):	ter the mode							Approximate Interval Betwonset and D	een eath
68760,	rificate be executed ig physician and as the burial-transit	Medical Examiner	that intuitied events resulting in death) Last	cDue to (or a	s a consequ	ence of):		CER	TIFICATION	N PROVE	D BY MEDICAL ES				
.O. Box	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as it	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □Live birth 4 □Pregnant 9 □ Unknown	2 Fetal	death 3	⊒Ectopic pre ⊒Other (spe					23d.	Date of delive Month		ear
rds, P.	w requires that the de been signed by the s should be detached to	by	Part II. Other significant condition  Subdural Le	s contributing to death	but not resul	iting in the u	nderlying ca	use give	n in Part I.		23e. Did 1			the cause of de	
Vital Records,		Completed									24a. Was auto perfe 1∐ Yes			opsy findings a ompletion of ca 2 \( \text{No} \)	
Z II	sician: The certificate l rector, pag	Be	25. Was case referred to medical examiner?  1 Ves 25 No	Hospital:				Othe	r.		h (Check only			HOSP	ICE -
on or	iding Phys h. After this funeral dii	ion: To	27. Manner of Death  → Watural 5 Pending	1 ∐ Inpat		28b. Time of Injury Unkno	f 28	Bc. Injury Work	4 L Nur		ome 5 Resi		curred	ify) CENTI	ER
Division or	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	2 Accident investigat 3 Suicide 6 Could no 4 Homicide determin	be 28e. Place of in		ne, farm, str						Street and Nu	Imber or Rui	ral Route Numb kinghar	n Dr.
	e Hospita 124 hours e Funerai letely filled	ical	(Check only 2 Medical Ex	Physician: To the bes aminer: On the basis	of examinati	on and/or in	vestigation,	in my op	piπion, deat	d place, th occur	and due to the	cause(s) and , date and pla	l manner as ce, and due	to the cause(s)	
	To th withir To th	Me	29b. Signature and title of contifier		D		29c.	License D3	number 235	3		29d. Date sig	gned (Month	, Day, Year) 2008	
•	14/2		29b. Signature and title of certifier  30. Name and eddres of person with the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con	no complete cause of	death (Item	23a) (Type,	Print) Dri	ve, S	uite l	=	Steven	sville,	MD 2	1666	
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	008 Regis	trar's Signati	ure de	K	_/				/			

P.O. Box 68760, Records, 9 Courter Signature stamp at Division or Vital

To the Hospital within 24 hours a To the Funeral I

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

0 9 2008

psrollet



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

TRAUMA

07

06,2008.

BALTIMORE, MO

3. Time of Death

State of Maryland / Department of Health and Mental Hygiene 2008 23780 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

Physician	
/Medical	
Examiner	

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaning must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

an al	Doris B.	Murphy						July 6	, 2	008	9:15am <sup>M</sup>
er	4a. Facility Name (I	f not institution, giv	e street and nur	mber)		4b. City, Town	or Location of Dea	ith	4	c. County of Dea	th
		chard Vi				Gaithe				Montgome	
	5. Social Security N 216-44-68 Usual Residence of	884	Sex I□M 21XIF	7. Age (In yrs. Ia 96	ast birthday) Yrs.	If Under 1 Yea Months Day			rth ay, Yea 5, 1	9. Bir 2911 Nev	thplace (State or Foreign ountry)  V York
	10a. State	10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits
ţo	Maryland	Montgom	erv	Ga	aither	sburg					1 □ Yes 2X No
irec	10e. Street and Nur		<u> </u>			10f. Zip Code	)		10g. (	Citizen of What Co	ountry?
al D	12129 Or	chard Vi	ew Road			20878	3		Un	ited Sta	tes
ner	11. Marital Status		12. Was Dece	edent Ever in U.S	3. 13.		f Hispanic Origin?	Specify Yes or N		14. Race - Ame	erican Indian,
Fu	1 Never Marri	ied 2 Married	Armed For	2 X No		1 ☐ Yes 2 🖾 N		rto Hican, etc.)		Black, Whit	e, etc.
l by	3 🔀 Widowed	4 Divorced	If Yes, Giv Year or Da	ve ates:		ILITES ZENIN	o Specify:			Specify: WI	nite
Completed by Funeral Director	(Spec	15. Decedent's E	ducation ade completed)		16a. Dece	dent's Usual Oc	upation ne during most of w	orkina		Kind of Business	
ďμ	Elementary/Seco		College (1	-4or 5+)			ne during most of w red)				nstitutes
ပ္ပ	12			, , , ,	Execu	tive Se		457		Health	
Be	17. Father's Name (							ame (First, Middle	e, Maid	en Surname)	
မ		Edward B					Anna R				
	19a. Informant's Na					•	et and Number or i				Zip Code)
	1	M. Hugh	es (Dau				nka Drive	, Bowle,			Town State
	20a. Method of Disp 1 Burial 2	oosition ⊒Cremation 3 ☐	Removal from S	Siare i		osition (Name of matory or other p	,			Location - City or	
		5 ☐ Other (Special	· · · · · · · · · · · · · · · · · · ·	Arl			al Cem. 8		1		Virginia
	21. Signature of Fu	ineral Service Lice	1)/		120	2. Name and Ado D.East D	ress of Facility I eer Park urg, MD	Devol Fu Drive	nera	al Home	
	York	MOIY K	Surof	All table seen							A
		rt failure. List only	one cause on e	aused the death ach line.	. Do not en	ter the mode of o	lying, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Immediate Cause ( disease or conditio resulting in death)		a. Cong	estive H	Heart	Failure					
	resulting in death)	•	Due to (	or as a consequ	ence of):						
-	Sequentially list cor if any, leading to im	nditions,	b								
nine	if any, leading to im cause. Enter Unde Cause (Disease or	riving	Due to (	or as a consequ	ence of):						1
xan	that initiated events resulting in death) I		c	or as a consequ	ence of):					<del></del>	
alE			200.00	,0. 00 0 00.10040	.0.100 0.71						
dic			_d								
ysician/Medical Examiner	IF FEMALE: 23b. Was decedent	l prognant	23c. If yes, out	come of pregna	ncy					23d. Date of de	alivery
ciar	in the past 12,	months?	1 Live t	oirth 2  Fetal	death 3	☐ Ectopic pregna ☐ Other (specify)				Month	Day Year
	1 □Yes 24 9 □ Unknown		9 🗆 Unkn								
Be Completed by Pt	Part II. Other signif	icant conditions	contributing to de	eath but not resu	ilting in the u	inderlying cause	given in Part I.	23e. Did	tobacc	o use contribute t	to the cause of death?
q p								1 🗆	Yes	2 X No 3 ☐ F	Probably 4 Unknown
lete								24a. Wa	s an	24h Were a	utopsy findings available
μ								- auto	opsy formed	prior to death?	completion of cause of
ပိ	25. Was case refer	red to medical	1					1 □ Yes		No 1 ☐ Ye	s 2□No
	examiner?		Hospital:	Inpatient 2 🗆 I	ED/Outration	all boat	ther:	eath (Check only		0.000	
T.	27. Manner of Death		28a. Date	of Injury	28b. Time o	III 3 LI DOA	4 ⊔ Nursing	28d. Describe		6 ☐ Other (Spe	ecify)
tio	1 X Natural 2 Accident	5 Pending investigatio		th, Day, Year)	Injury		fork? □Yes 2□No				
fica	3 ☐ Suicide	6 Could not b	e 28e. Place	of Injury - At ho	me, farm, str	reet, factory, offic	e	28f. Location	(Street	and Number or Fi	Rural Route Number,
erti	4  Homicide	determined	buildi	ng, etc. (Specify	()			City or To	iwn, St	ate)	
a C	29a. Certifier	1⊠ Certifying Pi	hysician: To the	best of my know	wledge, deat	th occurred at the	time, date and pla	ice, and due to th	e cause	e(s) and manner a	as stated.
Medical Certification: To	(Check only one)	2 Medical Exa	miner: On the b	asis of examinat ner stated.	tion and/or in	nvestigation, in m	y opinion, death oc	curred at the time	, date a	and place, and du	e to the cause(s)
Me	29b. Signature and	title of certifier	4			29c. Lice	ense number		29d.	Date signed (Mon	th, Day, Year)
	1	Some	Ann	Zn.D.		D	44967		J	uly 7, 2	008
	30. Name and addr	ess of person who	completed cau	- 40 1000	23a) (Type					<i>y</i> • <i>y</i> =	
		V. Humbur		,			e, Bethes	da, MD	2088	19	
te	31. Date filed (Moni						,	•			
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Registrar

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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 04<sup>Day</sup> Month 07 **Physician** 2008 BERNARD MORRIS 5:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 9330 ALCONA STREET PRINCE GEORGES LANHAM 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/04/1938 9. Birthplace (State or Foreign **Funeral** M 2□ F Months Hours Min 579-46-7887 70 WASHINGTON, DC **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location iral", or items 23a or 28a-f sh Examiner must be notified Yes 2 □ No Director MD PRINCE GEORGES LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9330 ALCONA STREET 20706 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: Black, White, etc. 1 Never Married & Married Maryland 21215-0036 1 ☐Yes 2☐No Specify. ۵ BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EUGENE AIKENS BERNICE MORRIS if item 27 is marked or other traumatic of ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EUGENE C. MORRIS/WIFE 9330 ALCONA STREET LANHAM, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page: Department o important: if any injury or RESURRECTION CEMETERY 7/10/2008 4 □ Donation 5 □ Other (Specify) CLINTON, MARYLAND 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Sery 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part 1. Emer the dispase, or complications that caused the death, shock, or hear failure. List only one cause on each life. Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and the buriai-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, <u>۾</u> 1 Yes 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has filled in by the funeral director, page 2: autopsy certificate 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and npleted cause of death (Item 23a) (Type, Print) 19€ State Registrar

DHMH 17 Rev 1/2001

Baltimore.

P.O. Box 68760.

Division of Vital

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Barbara Mike July 4,2008 11:18. AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Lutheran Home Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F 578-28-9540 84 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "naturel", or items 23a or 28a-1 show traumatic event, the Madical Examinations to notified at Md. Montgomery Yes 2 No Director Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701- Veirs Drive 20850 USA filed within 72 hours after death Hygiene. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be fi and Mental H ie marked ot Elias Dacy Carrie Dacy Nimer 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pernit. Pages 1 and 2 sh Department of Heelth and Importent: If Item 27 ie m any njury or other traum 2005: Georgette Parsons- Daughter-13912 Carlson Farm Dr. Germantown, Md. 20874 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Parklawn Mem. Park 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7/7/2008 Rockville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serv & Licensee 22. Name and Address of Facility W.h Ave., NW 20007 2222-Wisconsin Hysong Co., Inc. Washington, DC 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List or you e cause in  $\frac{1}{2}$  ch line. Approximate Interval Betw nset and Death Immediate Cause (Final Preum onia **Physician** Aspiration
Due (or as a consequence of): disease or condition resulting in death) days /Medical Examiner Due to (or as consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Advanced The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 an/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Year Physici 4 Pregnant at time of death 5 Other (specify) signed by the sid be deteched 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 ☐ Probably 4 ☐ Unknown Completed 1 ☐ Yes 2 ☐ No peripheral URSCULAT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 3 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: After this certification funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending Injury 1 Yes 2 No investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerei Dire 4 Thomicide Descritiving Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0050612 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Samuel Maller- 9701-Veirs Dr., Rockville, Md. 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

2. Date of Death

Day

2008 Year

10:30a M

Physician /Medical	
Examiner	

1 - For State Registrar

Decedent's Name (First, Middle, Last)
Oscar Pearson

with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed the attending physicien has Director:

Division of Vital Records, P.O. Box 68760,

July 9, 4a. Facility Name (If not institution, give street and number) 7413 17th Ave. 4b. City, Town, or Location of Death Hyattsville, Md. 4c. County of Death P.G. Birthplace (State or Foreign Country) 5. Social Security Number 229-22-4395 7. Age (In yrs. last birthday) 6. Sex Funeral<sup>\*</sup> M☐M 2☐F 80 Director Usual Residence of Decedent 10b. County P.G. 10a. State 10d. Inside City Limits 10c. City, Town or Location Le, Md 28a-f show "natural", or iteme 23s or 28s-f shov Md. 1X Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 7413 17th Ave. 20783 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 ie marked other then "natural", or item any injury or other traumatic event, the Medical Exercited PAGE. Yes 2 No 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: þ Yes. Give 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) G.P.O. Elementary/Secondary (0-12) College (1-4or 5+) Printer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Oscar Pearson Sr. Lottie Smith 2 19a. Informant's Name/Relationship (Type, Print)
Dorothy Pearson-Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7413 17th Ave. Hyattsville, Md. 20783 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (realize or Chelifer), crematory of other place)

Chelifennam Veterans 7/16/08 Cheltenham, Md. 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 1313 .C. 20001 6thStNWWash. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robinson Funeral Home 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END STAGE CONGESTIVE disease or condition resulting in death) HEART Due to (or as a consequence of): Sequentially list conditions. r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 1 Matural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours Funerel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. vithin 2 29b. Signature and title of certifier: 29c. License number 29d. Date signed (Month, Day, Year) D16619 aungay Soary MD 30. Name and odress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

C. VERGARA- SOARES

2008

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

4041 POWDER MILL R.D. CALVERTON MD. 20765

	-	For State Registrar	State	of Ma	arylan	•	rtment d tificate			Mental Hy		2008	23785
Physician		1. Decedent's Name (First, Middle, Last)								2. Date of De Month JULY	ath		3. Time of Death
/Medical	ı	NANCY LEE		41. O'). T				2,	2008	7:55 A M			
Examiner		4a. Facility Name (If not institution			33 T			ation of Death			County of Death		
Funeral		FREDERICK MEM  5. Social Security Number	6. Sex	7. Ag		last birthday)	FREDI If Under 1 Y	ear If L	Jnder 24 Hrs.	8. Date of Bir (Month, Da		FREDERIC 9. Birthp Cour	place (State or Foreign
Director		217-42-0878	1 □ M 2 <b>X</b> □ F	=	6	55 Yrs.	Months D	ays Ho	ours Min.	Dec 12,	194	2 Wash:	ington, D.C
and w	- 1	Usual Residence of Decedent  10a. State 10b. County			10c. City	y, Town or Loc	cation		-			1	I0d. Inside City Limits
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and 2 s and 2 s ealth an 27 is 1	]	Nanette L. Bobac		ter							-	MD 2174	
item item		20a. Method of Disposition	_		20b. P	lace of Disposemetery, crem	sition (Name o	f place)	i	Date	20c. Loc	cation - City or To	own, State
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permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr		21. Signature of Funeral Service	icensee Head	tte.	MO12							P.O. Box	x 784 ∍, MD 21029
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Attending Physician: The law requires that the death certificate has been signed by the attending by the funeral director, page 2 should be detached for use as different To Re Completed by Physician/Me	5	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No	1 □ Li	ve birth	2 Fetal	Ideath 3	Ectopic preg Other (speci				-	23d. Date of deliv Month	Day Year
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g Physical direction		27. Manner of Death	28a. D	ate of Inju	iry	28b. Time of Injury		Injury at Work?		28d. Describe			197
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To the within To the comp		29b. Signature and title of certifier			. /		29c. Li	cense nur	mber		29d. Date	e signed (Month,	Day, Year)
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(3)20	- 1	30. Name and addless of person							1m 011	701			
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State Registrar		JUL 1 0	2008	A Pega	18.1 J	ture	sele.						

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	_		1 - State Registra AVEND#24a, bperMD, 7/15/08, EMW, Moco Certificate of Death  1. Decedent's Name (First, Middle, Last)												
	Physicia	an	Phillip W. Raines							Day	3. Time of Death				
40	/Medic		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death								008 y of Death	11:40P M			
	Examin	er	Shady Grove Adve								Montgomery				
	Funeral				ge (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs		h	9. Birthp	lace (State or Foreign			
	Director		214-56-9115	1 <b>X</b> ) M 2□F	58	Yrs.	Months Days	Hours Min.	Dec. 23		Coun	many			
	70		Usual Residence of Decedent	-					DCC . 23	, 10 10					
	rylan show	_	10a. State 10b. County		10c. City,	Town or Loc	cation				10	Od. Inside City Limits			
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	er 2	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	try?			
	ath w	ra	26 Brookes Aver					0877			ed St				
	er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	>	5.   13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S ın, Mexican, Puer	Specify Yes or No- to Rican, etc.)	-   14. Ra   Bla	ce - Americ ack, White, e				
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21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show with the Medical Evaniner must be notified at	ed	15. Decedent's	Education		16a. Deced	ent's Usual Occup	ation		16b. Kind of E	Business/Inc	lustry			
75	iin 72 ii "ing Media	Completed	(Specify only highest Elementary/Secondary (0-12)	ī	E.\	life. D	kind of work done o OO NOT use retired	1) -		Montgo	mery	County			
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Maryland	uld by Menta arked atic e	70	William Raines	<u>;</u>				Stell	a Matsui						
ar	2 shc and is ma		19a. Informant's Name/Relationship				g Address (Street				•	Code)			
<u>~</u>	and Health rm 27 her tu		Martha E. Kern /	Wite	last St		ookes Ave								
0	it of F If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3	I ☑ Removal from State	20b. Pla	ace of Dispos metery, crem copoli	sition (Name of natory or other place	e) Jul	Date v 12	20c. Location	- City or 16	wn, State			
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Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparmit of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Li	Tensee		D 22	Name and Address eVol Fune Gait	eral Home Thersbug	e, 10 Ea	st Deer	Park	Drive,			
			23a. Part 1. Enter the disease, or conshock, or heart failure. List of	omplications that cause	d the death.							Approximate Interval Between			
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9 x	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnan	ncy				23d D	ate of delive	arv			
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FFEMALE:   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown   23d. Date of delivery   Month Day									y)						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2:35 AM 2008 /Medical H. Ramirez 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Doctors Community Hospital Lanham | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March | 23,1931 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ₩ 2 □ F Months Days 640-22-3522 77 **Director** Mexico Usual Residence of Decedent 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1√ Yes 2 No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7457 Brenish Dr. 20879 Mexico Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2 □ No þ If Yes Give Specify: Mexican Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If item 27 is marked of Ramon Martinez Carlota Hernandez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8538 Adelphi Rd. Adelphi, MD 20783 Ramon Ramirez (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cementerio Municipal 7/14/2008 Tototlan Jalisco Mexico 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 Pa 1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. Approximate Interval Between Onset and Death In mediate Cause (Final disease or condition resulting in death) **Physician** rneumonia 180 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burlat-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) by the a ☐Yes 2 ☐ No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ducase DISHER Mellin 1 TYes 2 No 3 Probably 4 Munknown should I 24b. Were autopsy findings available prior to completion of cause of death? has e 2 s 24a. Was an r this certificate had are rail director, page 2 autopsy performed? yes 2 DNo Clostidonum Colition 1 □Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No ၉ 27. Manner of Death 1. Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 124 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

To the it completes 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8006-30-50 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) landover Hillo 4410 74th Ave eclam 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2008

			For State Registrar	State of Marylan	•	artment rtificate			and M		giene leg. No.	008	237	88
ı	Physici		1. Decedent's Name (First, Middle, La Francis R. Romane							2. Date of Dea Month 7/6/2		Year	3. Time of 5:05	Death A <sup>M</sup>
	/Medic Examin	_	4a. Facility Name (If not institution, given 12229 Wynmore La			4b. City,		Location o	of Death		4c. C	ounty of Deat	orge's	
	Funeral Director		Social Security Number 6. 5			If Under Months		If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day 1/6/19		9. Birt	hplace (State of	or Foreign
	iryland show	_	Usual Residence of Decedent  10a. State 10b. County		y, Town or Lo	cation							10d. Inside Ci	-
	n the Ma r 28a-f s	Funeral Director	MD Prince  10e. Street and Number	George's	Bowie	10f. Zip					_	en of What Co		
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al Exami			iam Shubert S					July 13, 2	008	1403 hrs		
		4a. Facility Name (if not in: 57 West Franklin	stitution, give street and nun Street	nber)		4b. City, Town, or Hagerstown		n .	4c. County of Dea Washington			
Funeral		5. Social Security Number		7. Age (In yrs. las	t birthday)	If Under 1 Yea		s. 8. Date of Bir	th(MM/DD/YYYY) 9.1	Birthplace (State or		
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2		Usual Residence of Deced		Idon City T	own or Local	ion				10d. Inside City Limits		
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aryland 8a-f sh 8t onc	Director	MD Was 10e. Street and Number	hington	Hager	stown	10f. Zip Code		1	10g. Citizen of What C	ountry?		
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<sup>rə</sup> hysićian		23a. Part I. Enter the dise failure. List only one	ease, or complications that ca	aused the death.	Do not enter	the mode of dying	, such as cardiad	or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and		
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J. B. it the de by the ached 1		Part II. Other significant	t conditions contributing to		sulting in the	underlying cause	given in Part I.	23e. Did	I tobacco use contribu	te to the cause of death?		
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rds, requir	lete								opsy prio	re autopsy findings available r to completion of cause of		
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Division of Vital Records, P.O. Be lad or Attending Physician: The law requires that the darent and are dretten and Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached	BeC	25. Was case referred to examiner?				26.Pla	ce of Death (Che					
of Vit ing Physic After this	2	1 ✓ Yes 2	No _	Inpatient 2	ER/Outpatie		Other Nur	rsing Home 5	Residence 6	Other: Scene		
n of National Ph.  th.  After the funeral		1 Natural 5		h, Day,Year)			Yes 2 No	unk	to flow injury occurred			
isio r Atter er dear rector r by th	ficat	2 Accident 3 Suicide 6	Investigation 28e Place	7/13/08 be of Injury - At he		<b>2:30 pm</b> reet, factory, office			(Street and Number	or Rural Route Number, City		
Division spital or Attentours after death reral Director: filled in by the	Certification:	3 Suicide 6 4 Homicide	X Could not be determined (Specify,	found a	t res	idence		Hager	stown, MD	ranklin St.		
Division  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: , completely filled in by the fi	edical 0	29a. Certifier 1 Certi	ifying Physician: To the be ical Examiner:On the basis	st of my knowledg	ge, death occ nd/or investig	curred at the time, gation, in my opini	date and place, a	and due to the ca	ause(s) and manner as ite and place, and due	s stated. to the cause(s)		
To 1 To 1	Med	29b. Signature and title of	and manner	stated.			nse number			(Month, Day, Year)		
		full 1	Ilm n	n		0.0	C.M.E.		July 14, 2008	3		
		30. Name and address of	of person who completed cau									
		Russell Alexand		Medical Exam		11 Penn Stree	t, B <b>al</b> timore,	MD 21201				
		31, Date filed (Month, Da	av Vearl 32	egistrar's Signaty	re A	AB						

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 11:40PM フレレン 2008 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death The Hebrew Home of Greater Washington Montgomery Rockville 5. Social Security Number . Sex 1M 2□F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. 02/18/1931 578-40-2069 Washington, DC 77 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1X Yes 2 No Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4601 North Park Avenue, #211 Chevy Chase USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No 1951 − If Yes, Give Year or Dates: 1953 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Liquor Retail Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Max Sandler Jean Braunstein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Sandler-Wife 4601 North Park Avenue, #211 Chevy Chase, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Mem. Gardens 7/6/2008 Olney, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facil Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BILATERAL PNEUMONIA Due to (or as a consequence of) Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CVA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DEMENTIA 24a. Was an autopsy

Physician /Medical **Examiner** 

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

23a or

or

'natural"

than

Department of Health and Mental Hygie Important: If Item 27 Is marked other any injury or other traumatic event, it once.

Examiner must be notified at

Director

Funeral

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Completed

MD

with the Maryland

death Items

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Examiner attending physician and for use as the burial-tran Physician/Medical been signed by should be detact þ Completed page Be 2 Certification: within 24 hours after death

To the Funeral Director:
completely filled in by the

Hospital or Attending Physician: The law requires that the death certificate be executed

After

within 24 To the I

Division or Vital Records, P.O. Box 68760.

IF FEMALE: 9 Unknown 25. Was case referred to medical

3 ☐ Suicide

29a, Certifier

4 Homicide

(Check only one)

perform 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

examiner? 1 ☐ Yes 2 No	Hospi
27. Manner of Death	28
1 Natural 5 ☐ Pending	
2 ☐ Accident investigation	on

investigation 6 Could not be

8a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKUI ) MD KORZAN

State Registrar

Medical

31. Date filed (Month, Day, Year) 32 Registrar's Signature Physician /Medical **Examiner** 

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other i any injury or other traumatic event, II

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at

Director

Funeral

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burial-tran 24 hours after deatl

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Medical (

I Examiner	if any, leading cause. Enter L Cause (Diseas that initiated evresulting in dea
nysician/Medica	IF FEMALE: 23b. Was dece in the pas 1 ☐ Yes 9 ☐ Unkn
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To Be C	25. Was case examiner?
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30. Name and address of person while comp

0 9 2008

31. Date filed (Month, Day, Year)

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect.  C. Congestive Due to (or as a consect.  Due to (or as a consect.)	Heart Fail	ure		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of 6 9 □ Unknown	al death 3□Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions of Chronic Renal Fac		sulting in the underlying	cause given in Part I.		use contribute to the cause of death
				24a. Was an autopsy performed?	24b. Were autopsy findings avair prior to completion of cause death?  1 □ Yes 2 No
25. Was case referred to medical examiner?	si .		26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ I	OOA Other: 4 Nursing	Home 5 X Residence	6 ☐Other (Specify)
27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ary occurred
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fact	ory, office	28f. Location (Street a City or Town, Star	and Number or Rural Route Number te)
	nysician: To the best of my kn miner: On the basis of examin and manner stated.				s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifier	4	2	9c. License number	29d. D	ate signed (Month, Day, Year)

To the I within 2

filled in by

completely

Gaby Tesfaye, M.D. 6525 Belcrest Road Hyattsville, Maryland 20782 Registrar's Signature

ted cause of death (Item 23a) (Type, Print)

D0052555

July 8, 2008

		ı	1- State of Maryland / State of Maryland /	Depa Ce	artment of F rtificate of	lealth and M Death	ental Hygi Re	iene <sub>eg. No.</sub> 20 (	08 23792
	Physici		1. Decedent's Name (First, Middle, Last)  Joan		ipper		July 3,		3. Time of Death
2	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4715 Edgewood Road			r Location of Death		4c. County of	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b	birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth Feb. 21,		Birthplace (State or Foreign
	D		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	wn or Lo	cation				10d. Inside City Limits
	the Mar 28a-f sl	ector	Maryland Prince George's Colle	ge P	ark		1/	ng. Citizen of Wha	1 XYes 2 No
	th with t	Funeral Director	4715 Edgewood Road		20740			United	•
9800	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygjene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Eventual to the further at	δ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces  1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto F Specify:		Black, \ Specify:	American Indian, White, etc. White
21215-0036	ithin 72 h ne. nan "natu Medical	Completed	(Specify only highest grade completed)	(Give life. I	dent's Usual Occup kind of work done DO NOT use retired 1 Coordin	during most of workin d)	9	IGB. Kind of Busin United S of Agri	tates Dept.
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ylan	2 should be filed within n and Mental Hygiene. is marked other than raumatic event, the M.	To B	Joseph Pompieri				razier		
, Mar	1 and 2 sh Health and em 27 is m ither traum		David A. Skipper -son 4			Road Coll			
Baltimore, Maryland	e = 5		1 Burial 2 □ Cremation 3 □ Removal from State Sperr	tery, crer	sition (Name of natory or other place 1e Cemete	ery 7/9/2		Sperryvi	y or Town, State 11e, Virginia
Ball	permit. Pa Departmer Important: any injury once.		21. Signature of Funeral Service Ligensee	Ď	Name and Addre One 10 V 400 Powde	Borgwardt r Mill Ro	Funeral ad Belts	l Home, l sville, l	PA Maryland20705
	Physician /Medical Examiner	ıer	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Diabetes Mell Due to (or as a consequence of the conditions, if any, leading to immediate or complete the conditions, if any, leading to immediate or complete the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cau	itus e of): ucti				est,	Approximate Interval Between Onset and Death
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		M	29b. Signature and title of certifier		29c. Licens		29	July 7,	
	(0		30. Name and address of person who completed cause of death (Item 23a		Print)	3496			
	- Cho	10	Mohammad Khalid, M.D. 12001 Ferra  31. Date filed (Month, Day, Year)  Registrar's Signature			eaton, Mar	yland 2	0906	
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 0 9 2008  M. Registrar's Signature	400	E CO				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artment of F	lealth and Death		giene Reg. No.	008	23793
			1. Decedent's Name (First, Middle						2. Date of De Month	ath Day	Year	3. Time of Death
	nysici: 'Medic		Yolanda E.	Sheppa	ard-Mil	1s			July 4			15:26 M
,	xamin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, Town, o	r Location of Dea			ounty of Death	
			Washington Ad	ventist H	Hospita	1	Takoma	Park		Mo	ntgomer	сy
Fu	neral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days					place (State or Foreign ntry)
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ъ,		-	Usual Residence of Decedent  10a. State 10b. County		10. 0	. T						
aryla	ig i	2		0-11-4-		ity, Town or Lo						10d. Inside City Limits 1- Yes 2 □ No
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Aith ti	20	Ö	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cour	ntry?
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er de	190	Funerai	11. Marital Status	Armed Fo		J.S.   13. \	Was Decedent of H If Yes, specify Cuba	lispanic Origin? ( an, Mexican, Puei	Specify Yes or No rto Rican, etc.)	- 14	<ol> <li>Race - Americ Black, White,</li> </ol>	
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.1215- within 72 ene.	Andio	Completed	(Specify only highes	grade completed)		(Give	kind of work done DO NOT use retired	during most of wo	orking	TOD: IXIII	3 01 0 2011 0 0 0 111	addity
with with	N ex	E	Elementary/Secondary (0-12)	College (	1-4or 5+)	Ma	il Clerk			Gov	ernment	Ē
Hygie A	ant,	BeC	17. Father's Name (First, Middle, L	ast)				18. Mother's Na	me (First, Middle	, Maiden S	iumame)	
Maryland 21 d 2 should be filed w th and Mental Hygien	C eV	To B	Unknown					Elean	or Shepp	ard		
and Men	Tam.	-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Street				Town, State, Zip	Code)
	rtra		Christopher Mil	ls – Husl	oand	800 8	Southern	Ave., SE	#1206 W	Vashir	ngton, I	OC 20032
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Pages	y or		1 Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		State		natory or other plac lemorial	1	· 11 26	OS T	andowa	w MD
Baltimore, bermit. Pages 1 ar Department of Hea	any Injury or o		21. Signature of Funeral Service L		na.		Name and Addre		The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon			
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DIVISION If or Attending after death. Director: After	oy the	Hica	3 ☐ Suicide 6 ☐ Could n	ned 286 Place	of Injury - At h	nome, farm, str	eet, factory, office				Number or Rura	al Route Number,
DIV alter	ic b	Certification;	4  Homicide determine	• build	ing, etc. (Speci	ry)			City or To	wn, State)		
e Hospital	y fille		29a. Certifier 1 Certifying	Physician: To the	e best of my kn	owledge, death	occurred at the tir	me, date and plac	e, and due to the	cause(s) a	ınd manner as s	stated.
10 Hc	letel	edical	(Check only 2 Medical E	xaminer: On the b	pasis of examination of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the sta	ation and/or in	vestigation, in my o	pinion, death occ	curred at the time,	date and p	place, and due to	o the cause(s)
To the Hospital within 24 hours a	completely	Me	29b. Signature and title of certifier	TAHM	ins	K Alfons	29c. Licens			29d. Date	signed (Month,	Day, Year)
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110		ŀ	30. Name and address of person v	vho completed cau	se of death (Ite	m 23a) (Type,	Print) TA	Amina	Shop "	Aun	ED -	2 - 1
(13	/		( - 0 1 1 .		7 - /	1	East	Silver	8h-9"	MI	2	0915
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 1:30 PM David 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 556 Pentwood sommere. If Under 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Min. Hours 1 M 2 □ F 250-36-111 Director 29-27 south Cerolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director Baltimore. MO 1 Pres 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pertwood Items 23a 21239 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Fulces: 1 Des 2 No If Yes, Give Year or Dates: 1952-1960 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 □Yes 2 ¼ No Specify þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) 12 108 CD2PS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wells 2 ar line 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pentwood 1556 Rol Batto MD claughte 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7-08 rson Forest Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
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20. Name and Address of Facility 21. Signature of Funeral Service Licensee Meleste Stern Gary L Rollins Frederick South [0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** munth 4119 cein disease or condition resulting in death) /Medical Due to (or sequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 1 □Yes 2 □No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 1 □ Yes 1 ☐ Yes Physiclan: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital Other: 4 \( \text{Nursing Home} \) 1 Yes 25 No Medical Certification: To After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Per of Death 28b. Time of 28d. Describe how injury occurred or Attending ospital c. 4 hours after dea....al Director; After to the fu 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) To the I within 2. and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOS74360 07-02-2008 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

HECTIVED MANNUEL MO 22 5: CFEEK ST Baltimere Mb 21201. 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUL 0 9 2008

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Month **Physician** 6, July 8:55 A M Jo Ann Wolfe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4124 Fishers Hollow Rd. Myersville Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Oct. 19, 1946 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F 220-54-4419 61 Director Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shor Examiner must be notified at Myersville MD Frederick 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important; If item 27 is marked other than "natural", or items 23a or; amy njury or other traumatic event, the Medical Examiner must be or 4124 Fishers Hollow Rd. 21773 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Catherine Smith James L. Crummitt ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co2/1773 19a. Informant's Name/Relationship (Type. Print) 4124 Fishers Hollow Rd., Myersville, MD Ivan Wolfe (Husband) 20a. Method o Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Harmony Brethren 7/10/2008 Myersville, MD on 5 ☐ Other (*Specify*) f Fun ral &rvice Licer 21. Si ature Donald dd B. Thompson Funeral Home E. Main St., Middletown, MD 21769 Part1. E ter the diseas shock, o heart failure. t daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immoiste cause (Final leukemie **Physician** ogenous disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Mutiple Scierosi Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury consequence Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician the for use as the buria by Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Maryon Death 28a. Date of Injury 28b. Time of filled in by the funeral 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death. To the Funeral Director: / 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Johnson Prive Dr. Suit 135 196 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 0 9 2008 Registrar

DHMH 17 Rev 1/2001

		1 - State Registrar	state of Maryland	Certificate			ı	Reg. No.	2008	237	96
Physic /Medi		Decedent's Name (First, Middle, Last)     MABEL	WIGGINS				2. Date of Dea Month JULY	Day 6	2008	3. Time of De 8:42	eath A <sup>M</sup>
Exami		4a. Facility Name (If not institution, give stree PRINCE GEORGE S H	· ·	1	own, or Local	tion of Death			ounty of Death	GEORGE'	s
Funeral Director		5. Social Security Number 6. Sex 1 N	7. Age (In yrs. la 84		Year If U	urs Min.	8. Date of Birt (Month, Da FEB •	v, Year)	9. Birth Cou PA	place (State or F ntry)	-oreign
It all yitality Z IZ IZ-0000 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  MD  PRINCE GEO  10e. Street and Number  15110 JOPPA PLACE  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Educat (Specify only highest grade of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the county of the c	Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: ion ompleted)  College (1-4or 5+)		O721  Int of Hispani by Cuban, Me  Int No Spe  Occupation done during retired)  NIFE  18. N	most of working Mother's Name UNKNOW	g (First, Middle,	16b. Kind	JSA  4. Race - Ameri Black, White, Specify:  d of Business/Ir  PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTAL PRIVATE FURNAMENTA FURN	can Indian, etc. BLACK adustry	
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tificate be executed  By Physician and as the burial-transit	edical Examiner	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d. d. d.	CARDIAC A	RRHYTHMIA ence of): RY FAILURE ence of): ENOSIS						Interval Betwe	en eath
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law requires that as been signed by 2 should be deta	Completed by Ph	Part II. Other significant conditions contr	buting to death but not resu	lting in the underlying ca	use given in I	Part I.	1 🗆 24a. Was	Yes 2□	No 3 Pro	the cause of dea	nknown vailable
vital na sician: The l s certificate ha lirector, page	o Be Com	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Ho	spital: 1 <b>√</b> Inpatient 2□ [	ER/Outpatient 3 □ DO/	Othor:	Place of Death	1□ Yes (Check only o	ormed? 2XINo one)	death?	ompletion of cau X□ No	ise of
To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use 8.	Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day Year)  28e. Place of injury - At hoshiding, etc. (Specify	28b. Time of Injury M	ic. Injury at Work? 1  Yes	2 No	8d. Describe	how injury	occurred	ral Route Numbe	er,
To the Hospit: within 24 hours To the Funera completely fille	Medical C	29a. Certifier (Check only one)  29b. Signature and title officertifier	cian: To the best of my known: On the basis of examination and manner stated.	ion and/or investigation,	t the time, do in my opinion	n, death occurre	and due to the	date and	and manner as place, and due	to the cause(s)	
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		1	For State Registrar	State of Maryland	d / Depa		lealth and M	lental Hy	giene Reg. No.	2008	23	797
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last)  Ronald L. Williams,  4a. Facility Name (If not institution, give str			4b. City, Town, or	r Location of Death	2. Date of De Month 07	01	2008	3. Time of D 20:30	P <sup>M</sup>
	Examin Funeral Director		Southern Maryland H  5. Social Security Number 6. Sex		a <i>st birthday)</i> 53 Yrs.	Clinton  If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da	th y, Year)	9. Birthp Cour D. C.	lace (State or	
0000	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 71 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  M.D.  Prince Ge  10e. Street and Number  6801 Bock Rd.  11. Marital Status  1X Never Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces?  1  Yes  No If Yes, Give Year or Dates:	S. 13.	ington  10f. Zip Code 20744  Was Decedent of H If Yes, specify Cuba  1 □ Yes 2  No	lispanic Origin? (Sp an, Mexican, Puerto Specify:		10g. Citize Unite		es can Indian, etc.	
-61212	d within 72 h giene. er than "nati the Medica	Completed	15. Decedent's Educa (Specify only highest grade) Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of worl d)		Dept	of H.		
yland	ould be filed Mental Hyg a <b>rked othe</b> a <b>tic event</b> ,	To Be C	17. Father's Name (First, Middle, Last)  Bernard Arrington		T		18. Mother's Nam	Willia	ns		- 0 - 1 - 1	
baitimore, mar	permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum once.		19a. Informant's Name/Relationship (Type Ronald L. Williams,  20a. Method of Disposition    Burial 2 M Cremation 3 Re 4 Donator 5 Other (Specify)  21. Signature of Funeral Service licenses	rdale,	0746 orTown, State , Maryland ral Home, LLC							
	Physician /Medical Examiner	Examiner	23a Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final isease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	n. Do not en uence of):	where the mode of dylin	ng, such as cardiac	c or respiratory a	arrest,		Approximate Interval Betv Onset and D	ween
J. BOX 68/6U,	e death certificate be executed he attending physician and ed for use as the burial-transit	Physician/Medical Exa	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of t	ancy al death 3	□Ectopic pregnanc	:y		23	3d. Date of deliv		Year
Vitai Records, P.O.	The law requires that the death certificate ate been signed by the attending phys agge 2 should be detached for use as the	Completed by Phy	Part II. Other significant conditions con  Jever Dilayed (  Ocarte Lenal Fee	tributing to death but not res	10	underlying cause giv	ven in Part I.	1 □ 24a. Was	Yes 2□	24b. Were au	obably 4 Utopsy findings ompletion of c	Unknown available
Division or Vital F	or Attending Physician: ifter death. Director: After this certifics in by the funeral director, I	Certification: To Be Cor	25. Was case referred to medical examiner?  1	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)  28e. Place of injury - At h building, etc. (Speci	28b. Time 28b. Time Injury ome, farm, s	of 28c. Inju Wo M 1	ıryat ork? ∐Yes 2 ☐ No	ath Check onl  dome 5 □ Res  28d. Describe	2 ♣ No one sidence 6 how injury	1 ☐ Yes ☐Other (Special occurred		nber,
•	To the Hospital within 24 hours a To the Funeral I completely filled	Medical Co	29a. Certifier (Check only one)  29b. Signature and title of certifier	iclan: To the best of my knower: On the basis of examinating and manner stated.	owledge, dea ation and/or	investigation, in my	ime, date and place opinion, death occurse number	urred at the time	29d. Date	and manner as place, and due e signed (Month	to the cause(	s)
	2/2)		30 Name and address of person who co	mpleted cause of death (Iter	m 23a) (Type	e, Print)			-	,		

State Registrar

31. Date filed (Month, Day, Year)

10 1328 Somtem avenue Sf Soute 310 Washington DC 20032 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 31 per dyr 881 7-24-08 yt

1-24-08 yt

20 a-c, 22 per fn 882 8-13-08 yt

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 4:24 AM M July 15, Gwendolyn Arthur 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Hospital Montgomery Rockville 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Fore (Month, Pay, Year) 9. Washington DC 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🛱 F Months Days Hours Min. 54 579-74-3067 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Expuring it ust be in titled in Director 1 ☐ Yes 2 No MDMontgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 716 Crabb Avenue 20850 USA Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: black ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7; th and Mental Hygiene.
7 is marked other than "n: Elementary/Secondary (0-12) College (1-4or 5+) 12 housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk Edward Patterson ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. Carnetta Patterson/daughter 817 Archer Blvd Gaithersburg, MD 20878 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 7-31-08 4 ☐ Donation 5 <del>MOther (Specify)</del> Silver Spring, Md. in state 22. Name and Address of Facility Snowden Fineral Home Rockville Baltimore Street Baltimore, MD 21201 246 N. Washington St. Rolla 1d S. Wade, Baltimore Street Mirector 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate clause (Final disease or condition resulting in death)

a. 

repsiratory failure Approximate Interval Between Onset and Death NOUTS Physician /Medical Due to (or as a consequence of): Examiner pulmonary embolus Sequentially list conditions, Dire to (or as a consequence of). Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) ed by the a P.0. 9 Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ end stage kidney disease, sepsis, diabetes mellitus 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 D certificate 1 ☐ Yes Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 💢 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 58112 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laphe Kashis man (Month, Day, Year) 32. Registrar's Signature 31. Date filed State Elem & Speller Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

JUL 2 4 2008

9:09

2008

22,

JULY

KATHLEEN AGREISTI

State of Maryland / Department of Health and Mental Hygiene 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23799

	•	= State Registrar		Cert	tificate of	Death		Reg. No.	00	20133
il The		1. Decedent's Name (First, Middle, Last)					2. Date of De	eath Day	Year	3. Time of Death
Physicia /Medic		Kathleen	Μ.	Agr	iesti		July	22, 200		5:06 P M
Examin		4a. Facility Name (If not institution, give street and number	r)		4b. City, Town, o	r Location of Death		4c. County	of Death	
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Director		253-32-2344 <sup>1□ M 2</sup> ズF	83	Yrs.	month baye		Jan.	28, 1925	Ge	orgia
pg ,		Usual Residence of Decedent	100 City	Town or Loca	ation					10d. Inside City Limits
aryla shov	_	10a. State 10b. County			allOII					1 □ Yes 2 X No
e Ma	Director	Maryland Baltimore	T	owson				10 00 0	MI 0	
or 2	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of V		ntry?
ath w	<u>ra</u>	26 Bardeen Court			212				S.A.	- Indian
er des	Funeral	11. Marital Status 12. Was Deceden Armed Forces	?	13. W	as Decedent of F Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	necity yes or Non Rican, etc.)	0- 14. Had Blad	ck, White,	ican Indian, etc.
Iryland 21215-0036 should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Evanders.	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give  3 ☐ Widowed 4 ☐ Divorced Year or Dates	•	1	□Yes 2□ <b>X</b> No	Specify:		Specify	y: 1 <sub>4</sub> 1	hite
OO hours	ğ			16a Decade	ent's Usual Occup	nation		16b. Kind of B		
15-	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give k	ind of work done O NOT use retire	during most of work	king			,
withii with	ᇤ	Elementary/Secondary (0-12) College (1-40)	5+)		nemaker			Own H	ome	
d 2 filed Hygi ther	ပို	17. Father's Name (First, Middle, Last)		11011	Ciliare	18. Mother's Nam	ne (First, Middle			
antal be red or ever	) Be	Ernest Jones					Carrie	Mat	thew	S
aryla should I and Men s marke umatic	욘	19a. Informant's Name/Relationship (Type. Print)		19b. Mailing	Address (Street	and Number or Ru				
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Pages Pages nent of ant: If it		1 Burial 2 ☐ Cremation 3 ☐ Removal from Stat	• Che	retening	atory or other place Cemeter	ce) 7-29	_2000	Cholton	han	Maryland
Baltimore, Maryland 21215-0036 bernit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, I'm Madical Evan ance.		4 ☐ Donation 5 ☐ Other (Specify)  21. Shoat e of Runera Service Licensee	l A6	cer ans	Name and Addre	1 1 43				
Baltimore, permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.					050 York	Road T	UCK TOW	son fune Maryland	ra i I <b>212</b>	Home, Inc. 04
		23a, Part 1. Enter the disease, or complications that caus	ad the death							Approximate
	e va	shock, or heart failure. List only one cause on each	line.	Bo not onto	in the mode of dy.	ng, each ac caran				Interval Between Onset and Death
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xecu and	Examiner	that initiated events c	is a conseque	ence of):						
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BC leath atter	cial	in the neet 12 months?	≥ □ Fetal of at time of de		Ectopic pregnand  Other <i>(specify)</i> _	cy		M	onth	Day Year
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that the ned by detac	y P	Part II. Other significant conditions contributing to death	but not result	ting in the un	derlying cause giv	ven in Part I.	23e. Dio	I tobacco use con	tribute to	the cause of death?
rds puiree n sig	g D						1 🗆	]Yes 2∏ No	3□ Pro	obably 4X Unknown
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Re(he law e has age 2 s	ᇤ						_ per	formed?	death?	completion of cause of 2 □No
Sion of Vital Records, tending Physician: The law requires t leath. tor: After this certificate has been signe the funeral director, page 2 should be c		25. Was case referred to medical				26. Place of Dea	1 ☐ Yes		1 163	2 1110
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On ding th. After	Ē	1 X Natural 5 ☐ Pending (Month, I 2 ☐ Accident investigation	Jay, Year)	Injury		rk? ]Yes 2 □ No				
Division or Attend after death.	fice	3 ☐ Suicide 6 ☐ Could not be 28e. Place of I	njury - At hon	ne, farm, stre	et, factory, office		28f. Location	(Street and Num	ber or Ru	ral Route Number,
Div after d in t	Certification: To	4 ☐ Homicide determined building,	etc. (Specify)				City of f	own, State)		
spita nours nera y fille		29a. Certifier 1 Certifying Physician: To the be	st of my know	ledge, death	occurred at the t	time, date and place	e, and due to the	ne cause(s) and n	nanner as	stated.
To the Hospital of within 24 hours af To the Funeral Discompletely filled in	Medical	(Check only 2 Medical Examiner: On the basis and manner		on and/or inv	vestigation, in my	opinion, death occi	urred at the tim	e, date and place	, and due	to the cause(s)
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		30. Name and address of person who completed cause o	f death (Item :	23a) (Type, F	Print)					
20		DR. TARIQ MAHMOOD 2300 D	ULANEY	VALLI	EY RD.	TIMONIUM,	MD 210	093		
Sta	te	31. Date filed (Month, Day, Year) 32. Regis	strar's Signatu	ıre						
Registr	ar	JUL 2 4 2008	we to	y Bo	and s					
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ORIGINAL

		•	1 - For State Registrar	•		Certificate of	Death	Reg. I	2008	238	00
v _	Physici	an	1. Decedent's Name (First, Middle, Las					Date of Death     Month	Day Year	3. Time of De	
	/Medic		I	DAVID ROLA	AND AR			JULY 21		6:34	P <sup>M</sup>
7	Examin	er	4a. Facility Name (If not institution, give				r Location of Death		4c. County of Death		
	<del>San San San San San San San San San San </del>	- 19	CARROLL HOSPI'S  5. Social Security Number 6. Se		n yrs. last birtl		MINSTER  If Under 24 Hrs.	8. Date of Birth	CARROLI		Foreign
	uneral irector			7. Age {/	-	rs. Months Days	Hours Min.	7/11/19		place (State or F ntry) RYLAND	oreign
land	ow at		10a. State 10b. County	10	c. City, Town	or Location				10d. Inside City	Limits
Man	a-f sh iffed	tor	MD Car	croll	West	minster				1 X Yes 2	□No
th the	or 28, e not	Funeral Director	10e. Street and Number			10f. Zip Code		10g. (	Citizen of What Cou	ntry?	
ıth wi	23a ust b	ral	1 Webster St.			2115			USA		
er dea	terns er m	nne	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,		
<b>5-0030</b> 72 hours after death with the Maryland	of other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【XDivorced	1 XYes 2 No If Yes, Give Year or Dates:		1 □ Yes 2 <b>X</b> No	Specify:		Specify: WH	HITE	
<b>3-0030</b> 72 hours af	atural cal Ex	edt	15. Decedent's Ed	ucation	16a.	 Decedent's Usual Occup	ation	16b.	Kind of Business/Ir		
within 72	Medi	Completed	(Specify only highest gra	College (1-4or 5+)	1	(Give kind of work done life. DO NOT use retired	during most of work d)				
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2 should be	narke	၉		ARROLL ROI				MARGARE		- 0-4-)	
<b>≤</b> ₽ <b>±</b>	r 27		19a. Informant's Name/Relationship (7 DIANE J. TURNER	-DAUGHTE	R 10	Mailing Address (Street  N. Cran	berry Ro	l.,Westmi	.nster,	MD 211	57
Ore, ges 1 au t of Hez	If Item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Hemovai Rom State - i		Disposition (Name of y, crematory or other place			Location - City or T		
. Pages	lant		4 □ Donation 5 □ Other (Specify	) A	T COL	INTY CREMA					
Salti bermit.	Important: If any Injury o		21 Signatur of Funeral Service Licen	see		22. Name and Addre					
	_ 40 0,		23a. Part1 Enter the disease, or comp	lications that caused the	death Don	254 E. MA			STER, MI	Approximate	
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VISION r Attending	ector by the	fica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury	- At home, far	m, street, factory, office		28f. Location (Street	and Number or Ru	ral Route Numbe	er,
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To th	To th comp	Me	29b. Signature and title of certifier	MO		29c. Licens	52037		Date signed (Month	3 3	308
11	1		30. Name and address of person who	completed cause of doct	h (Item 23a) /		, – ( )	. 1 0	Juli C		
51			Sinu CHALKE	261		er Aren	e 11) é	57 min 3	1520		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1					
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 23801 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Richard Davis Bailey July 10, 2008 9:05 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 516 Front Street Perryville Cecil If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year May 16, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X**] M 2□ F 60 1948 Director 217-50-2133 Maryland Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner prust be nutified at 1 ☐ Yes 2 ☐ No MD Cecil Perryville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 516 Front Street 21903 USA or Itams 23a deeth v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Heelith and Mental Hygiene. Important: if itsm 27 is marked other than "natural", or itam any injury or other traumatic event, the Mudical Ferra Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White à If Yes, Give Year or Dates: 3 ☐ Widowed 4 ¥ Divorced ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Complete Elementary/Secondary (0-12) College (1-4or 5+) 12 systems analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Barnes Bailey Nora Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Barnes Bailey/son 108 Remington Circle Havre de Grace, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee KOnald S. Wade State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Dunknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No hes 1 Yes 2. No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 2 ER/Outpatient 3 DOA his 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending Injury 1. Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours e To the Funeral [ 29a. Certifier La Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Home

JUL 2 4 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BIOND

32 Registrar's Signature

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			T = For State Registrar	State of Marylai		rtificate of		F	Reg. No. 200	8 23802		
	Physici	an	Decedent's Name (First, Middle, Last	st)				2. Date of Dea Month	ath	3. Time of Death		
17	/Medic	cal	Anne L. Bogan  4a. Facility Name (If not institution, giv.	a street and numbers		4h City Town o	or Location of Death	July 1	.9, 2008 Yes	11:35 A <sup>M</sup>		
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e.	Funeral Director		213-20-0343	ех	. last birthday) Yrs.			8. Date of Birth (Month, Day Oct. 3,	0 0 1	Birthplace (State or Foreign Country) Maryland		
	land bw		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation				10d. Inside City Limits		
	Mary a-f she ified a	tor	MD Carro	011		Fin	ıksburg			1 □ Yes 2 📉 No		
	ith the	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?		
	sath w	eral	2430 Old Westmin	nster Pike	18 13	Was Decedent of H	)48 Hispanic Origin? (S	nacify Vas or No-	United St	ates merican Indian.		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 Never Married 2 Married  **T Widowed 4 Divorced	Armed Forces?  1  Yes 2 ANO If Yes, Give Year or Dates:	I	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 XNo	Specify:	to Rican, etc.)	Black, W			
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121	within lene. than the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemaker				Own Home		
Maryland 2	d 2 should be filed within th and Mental Hygiene? Is marked other than 'traumatic event, the Me	To Be C	17. Father's Name ( <i>First, Middle, Last,</i> Unknown	)			18. Mother's Nar Unkno	Name (First, Middle, Maiden Surname)				
ary	and N and N is mai	-	19a. Informant's Name/Relationship (	Type. Print)	19b. Maili	ng Address (Street	and Number or Ru	ural Route Numbe	er, City or Town, Stat	e, Zip Code)		
	1 and 2 Health em 27		Roy N. Bogan - S		2430	Old West	minster	Pike, Fi	nksburg,			
Baltimore,	Pages 1 nent of P ant: if ite ary or ot		20a Method of Disposition  1 Burial 2 Cremation 3	Hemovai irom State		osition (Name of matory or other pla	!		20c. Location - City			
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וסר	ding Phys n. After this funeral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of				now injury occurred	вресну)		
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			Jul 1.	VYY		000	519211		July 21,	2008		
	8		30. Name and address of person who 31. Date filed (Month, Day, Year)	completed cause of death (Ite	MN	2973 W	lanchest	eRI	Manch	ester Min		
	Sta Registi			008	J. A.	DEAGL)						

Registrar DHMH 17 Rev 1/2001 State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23803

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1. Decedent's Name	e (First, Middle,	Last)						2	2. Date of De	ath		3.	Time of Death
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/Medic Examin		4a. Facility Name (I		give street a	nd numbe		<u>,                                    </u>	4b. City, Town, o	or Location	of Death	7	4c. (	County of Dea	OI.	
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Funeral		5. Social Security N		. Sex		ge (In yrs. la	st birthday)	If Under 1 Year	If Unde	r 24 Hrs. 8	B. Date of Bir	th	9. Bit	thplace	(State or Foreign
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - For State Registrar 23804 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year BURMAN **Physician** FREDRIC 06:00 PM D. 20 2003 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A LEVINDALE HEBREW HOME BALTIMORE Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** 1₽M 2□ F Months Days Hours Min. 06/19/1941 Director 67 217-40-8672 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County a or 28a-f show the notified at show 1 ☐ Yes 2 X No Director BALTIMORE MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA r than "natural", or Items 23a 8 POMONA NORTH, 21208 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) U.S. AIR FORCE 5+ INTELLIGENCE permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **JOSEPH** DOROTHY HARRIS BURMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 POMONA NORTH, #7, BALTIMORE, MD ANN BURMAN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) OWINGS MILLS, MD 07/23/2008 HAR SINAI CONG. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC Physician NEUROENDOERINE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transil be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ੬ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 **X** No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes this Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide

 $\mathcal{S}\mathcal{U}\mathcal{R}\mathcal{M}\mathcal{A}\mathcal{N}$  ,  $\mathcal{F}\mathcal{K}\mathcal{E}\mathcal{D}\mathcal{K}\mathcal{I}\mathcal{C}$ Division or Vital Records, P.O. Box 68760,

after death. completely filled in by within 24 hours a Hospita 0 State Registrar

BABATUNDE 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

Medical

HYSICIAN 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVIN SITUE - HEBREW

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

MD

29c. License number DO064533

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2434 W.

29d. Date signed (Month, Day, Year)

07-21-2008

GERIATRIC CM Ave. BAUTIMONEMO 4215

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MALA 32 Registrar's Signature 2008

Amend #7,19a,perFH G884 10/23/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- Registrar #14. per Fh G881 7/24/08 Certificate of Death Reg. No. 2 Reg. No. 2008 23805 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 0506 M JUI 2008 URGO /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ARROL estminis 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number Sex 1□M 2XF **Funeral** Months Days Hours 216-54-4097 Yrs. 86 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director TMIN S 10g. Citizen of What Country 10e Street and Number 10f. Zip Code Funeral 14. Race - American India White 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black\_White, etc ☐ Never Married 2☐ Married 1 □Yes 2 If Yes, Give 1 □Yes 2 No Specify: ģ 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life\_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Magonee." Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) touse wi mes 16 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be auro ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ₩OGUE - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) town 22. Name and Address of Facility 21 Simpury of Funeral Service Licenses BERTY 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause of each line. Approximate Interval Between Paset and Death Do not enter the mode of dying, such a cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** 1201006916 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.O. 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an , page 2 s has autopsy the Hospital or Attending Physician: The this certificate 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 6 Other (Specify) 1+05 pics Hospital: Other: 4 Nursing Home 5 Residence 2 No 1 Yes 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kus Stow Wilbu 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JULY 16, 2008 Year **Physician** 6:45p M LAURA BURGESS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner 8502 GLEN MICHAEL LANE APT 101 RANDALLSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7-10-1928 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F SOUTH CAROLINA 80 212-80-2444 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10a. State 10b. County 1 ☑ Ves 2 ☐ No Director BALTIMORE RANDALLSTOWN MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 18 23a c 8502 GLEN MICHAEL LANE APT 101 21133 USA should be filed within 72 hours after death on Mental Hygiene. marked other than "natural", or items 23: Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates: 14. Race - American Indian, r than "natural", or items the Medical Examiner ma Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK ð 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be PHOEBE FULTON PINKNEY EVANS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 19a. Informant's Name/Relationship (Type. Print) LAURA BROGDON (DAUGHTER) 8502 GLEN MICHAEL LANE APT 101 RANDALLSTOWN, MD. 20a. Method of Dispositig 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Oremation 3 ☐Removal from State 7-24-2008 MT. ZION CEMETERY BALTIMORE, MARYLAND 5 Other (Specify) 4 ☐ Donation 21. Signature of Funeral Service Licensee JONA HAN HIBNER. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. <u> 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. EREBRO VASCULAR Immediate C hise (Final disease v Andition resulting in death) DISEASE HTHEROSCLEROT **Physician** /Medical Due to (or as a consequence of): **Examiner** Se mentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. physician the attending pl IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4□Pregnant at time of death P.O. P signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 4. Onknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy certificate 1□ Yes 2□No or Attending Physician: funeral director. 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 🔲 Yes this 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural Injury 5 Pending s after death. investigation 1 □ Yes 2 □ No 2 Accident the Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28595 Laur

Registrar

State

TASNEEM

31. Date filed (Month, Day, Year)

1

AVE,

SUITE 203

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 31 per dvr 8817-24-08 vt
State of Maryland bepartment of Health and Mental Hygiene 2 0 0 8 23807 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Modical Evanture must be multiped at

Baltimore, Maryland 21215-0036

**Funeral** Director

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed

and burial-trar ţ been signe should be within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

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deatn. <b>ctor</b> ; After th y the funeral	ification:	27. Manner of Dea 1 Natural 2 ☐ Accident	5 Pending investigat	ion	n, Day, Year)	28b. Time Injury	М		at Yes 2□	No	28d. Describe l				
ecto by t	l≝	3 ☐ Suicide	6 Could not determine		of Injury - At he	ome, farm, s	treet, factory, o	office			28f. Location (	Street an	d Number or Ru	ıral Rout	e Number,

State Registrar

Medical Cer

29a. Certifier

29b. Signature and title of certified

HOUSE - STAFF

29c. License number RES 0001

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accurred at the control of the cause (s).

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANEEN ALBAK

HANOVER STREET, BALTIMORE MD

2008 Seem & Jack 3001 SOUTH 1

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year CAROLYN CROSBY 18:50 M 07 19 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A GOOD SAMARITAN HOSPITAL BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 TXF 45 219-76-8450 Director MARYLAND 1-3-1963 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 X Yes 2 ☐ No BALTIMORE Directo MD. N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ural", or Items 23a or Examiner must be 213 DOUGLAS CT 21231 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: BLACK þ 3 Widowed 4 Divorced "natural", Completed 7 is marked other than "nature traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION HOSPITAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I မ BERNARD COOPER EFFIE LEAKE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a EFFIE COOPER(MOTHER) 213 DOUGLAS CT. BALTIMORE, MARYLAND 21231 20a. Method of Disposition 1 → Burial 2 → Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If It any Injury or c 3 Removal from State 4 ☐ Donation b □ Other (Specify) MT. ZION CEMETERY 7-29-2008 BALTIMORE, MARYLAND 21. Signature eral Service HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Ever the disc shock of heart failu Immediate vives (Final disease or condition er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. SEPSIS Physician /Medical Due to (or as a consequence of): Examiner RENAL DISEASE STAGE END Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed slcian and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 4☐Pregnant at time of death signed by the a d be detached for 1 ☐ Yes 2 ☑ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient မ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Within 24 hours are To the Funeral Dir 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Agyhotol MD RES-000 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GDDD SAW) ARITAN HOSPITAL ,5601 LOCH RAYEN BLYD, BALTIMORE ABHIJEET GHATOL mp-21239 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

CAROLYN

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2008

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08-05560 Robert Duffy, Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 23809

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Physicia		Decedent's Name (First, Midd	le,Last)		-			Date of Dea     Month	ath Day Year	3. Time of Death	
edical Exami	ner	Robert Edward	d Duffy Jr.				100	July 20, 2	2008′	1950 hrs	
		4a. Facility Name (if not institution	_	ber)	4k	. City, Town, o	r Location of	Death	4c. County of E	eath .	
		Upper Chesapeake M	ledical Center			Bel Air			Harford		
Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. last	birthday)	If Under 1 Ye			irth(MM/DD/YYYY) 9	oreign	
Director		157-64-2334	1X M 2 F	41	Yrs.	Months Da	ys Hours	Min. Feb.	7, 1967	Country New Jersey	
	1	Usual Residence of Decedent									
any	Γ	10a. State 10b. County		10c. City, To	wn or Locatio	n				10d. Inside City Limits	
nd show	5	Maryland Har	ford		Abino	rdon				1 Yes 2 X No	
ie Maryland or 28a-f show any fied at once.	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?	
the Mare 1	吉	420 Oakton Wa	av			21	009	_	USA		
with is 23;	<u>_</u>	11. Mantal Status	12. Was Dece	dent Ever in U.S.	13. Was	Decedent of H	ispanic Origi	n? ( Specify Yes or N	lo- 14. Race - /	American Indian, Black,	
item item	Funeral	1 Never Married 2 N	Married Armed For	ces?	If Ye	s, specify Cuba	ın, Mexican,	Puerto Rican, etc.)	White, e	erc.	
fter d		3 Widowed 4 X Div	vorced If Yes, Give Year	, ,,,	1	Yes 2 X N	o specify:		Specify: V	White	
ours a	d b	15. Decedent's Education (Spe	ecify only highest grade	completed) 16	6a. Decedent	s Usual Occup	ation (Give ki	ind of work done	16b. Kind of Busin	ness/Industry	
72 hc	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)									
r tha	E D	12			Pı	cinter				Design	
5-0- led w othe the h		17. Father's Name (First, Middle						s Name (First, Middle			
21215-0036 yuld be filed within 7 Mental Hygiene. marked other than te event, the Medica	B	Robert Edward					and the second second	y E. McCo			
	유	19a. Informant's Name/Relation				Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coo. 116 Walnut Hill Court, Abingdon, MD 21009					
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is		Tracy Wolgram	/ Sister					Court, Abi	ingdon, MD	21009 ity or Town, State	
r free		20a. Method of Disposition  1 Burial 1 X Cremation	n BRemoval fro		matory or oth	tion (Name of o er place)	emetery,	Date	200. Location - 0	ity or rown, otate	
Page lent o		4 Donation 6 Other S	/ -/	Hil]	ltop Se	ervice	Corp.	7-28-08	Towson	, Maryland	
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Physician		23. Part I. Enter the disease, of failure. List only one cause		used the death. D	o not enter th	e mode of dyin	g, such as ca	ardiac or respiratory a	arrest, shock, or hear	Between Onset and	
/Medical xaminer	8 14	Immediate Cause (Final diseas	No. of Charles I	ıries						Death	
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		Sequentially list conditions,	b						_		
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Box 687 ne death certific the attending	sician	1 Yes 2 No 9 U	nknown g Unkno	ant at time of deat	n 5 Oth	ner (Specify)					
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<b>IS,</b> quires	ted			<del>_</del> .				24a. Wa	as an   24b. W	ere autopsy findings available	
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Vit hysic this c	To E	1 Yes 2 No	Hospital: 1	npatient 2 🗸 E			Other <sub>4</sub>	Nursing Home 5	Residence 6	Other:	
n of ing Pt After funeral	ڃ	27. Manner of Death	28a. Date (Month Jul 20, 2	of Injury 2 Day Year)	28b. Time of I 1852 hrs		njury at Work	Operator	ce how injury occurre of motorcycle to	auto collision	
ion tendicath.	;	Pe	restigation				Yes 2 🗸	NO .			
Division tal or Attendi rs after death. al Director: /	≝	3 Suicide 6 Co	uld not be 28e. Place	e of Injury - At hon	ne, farm, stree	et, factory, offic	e building, et	or Towr	n, State)	r or Rural Route Number, City	
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e Hos 124 h e Fur letely	<u>8</u>	29a. Certifier 1 Certifying	Physician: To the bes	t of my knowledge	e, death occur	red at the time	date and pla	ace, and due to the ca	ause(s) and manner : ate and place, and du	as stated. le to the cause(s)	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical		and manner s	tated.						d (Month, Day, Year)	
	≥	29b. Signature and title of certi	ner				nse number				
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		30. Name and series of person				4 D C'	- Delle	ND 04004			
6		Pamela E. Southall,		Medical Exam		Penn Stre	et, Baltın	nore, MD 21201			
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			For State	State of Mar	ryland / [	Depa	artment of F	dealth	and Me			008	2381	0
			Registrar  1. Decedent's Name (First, Middle, La.	st)		Cei	inicate of	Deall		2. Date of Dea	eg. No.		3. Time of Death	
	Physicia		Ruth A. Dudzak	,						Month July	22, 20	008 Ye ar	7:10P M	
arina.	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, o	r Location	of Death			nty of Death		
-			Stella Maris				Timor					altimo		
	Funeral		5. Social Security Number 6. S	□M 2FFF	(In yrs. last bir	rthday) Yrs.	If Under 1 Year Months Days	Hours Hours	Min.	B. Date of Birth (Month, Day eb. 19	; Year)	Co	hplace <i>(St</i> ate o <i>r Foreig.</i> untry) nsylvania	n
	Director		219-30-0511 Usual Residence of Decedent		90			<u> </u>	F	eb. 19	, 1910	ren	lisylvania	
	ryland ihow	_	10a. State 10b. County		10c. City, Tow	n or Lo	cation						10d. Inside City Limits	
	Ba-f s	Director	Maryland Baltimo	ce	Cato	nsv:							1 □ Yes 2¥ No	_
	a or 2	Ö	10e. Street and Number				10f. Zip Code	,		1	I0g. Citizen	of What Co	untry?	
	hours after death with the Maryland tural", or items 23a or 28a-f show	Funeral	413 Harwood Road	12. Was Decedent Ev	er in U.S.	13. \	21228		rigin? (Speci	ifv Yes or No-	USA 14. I	Race - Amer	rican Indian,	_
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215-0036	ours a	d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I∐Yes 2⊠ No	Specify	y: 		Spe	ecify: W	hite	
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7	withir iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	)		Registere	· .	rse		Medi	cine		
פ	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene.  Is marked other than "natural", or items 23a or 28a-f show aumatic event, it s. Ne dier Expring munity or notified.	BeC	17. Father's Name (First, Middle, Last,	1	I			18. Moth	ner's Name (	First, Middle,	Maiden Suri	name)		
/Iand	uld be Ments arked	2	Walter Watson					Mar	y Johr	1				
Mar	2 sho	6 5	19a. Informant's Name/Relationship (		1		g Address (Street							
e e	1 and Health sm 27 ther t		Jolene G. Buck  20a. Method of Disposition	Daughter			Harwood I		Cator		, Mar			_
5	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 Is marked any Injury or other traumatic esones.		1 🔀 Burial 2 🗆 Cremation 3 🗆		cemete Meado	ry, cren	sition (Name of natory or other place dge Mem . I	ce) Park				•	Maryland	
ащто	artme ortan injur		4 ☐ Donation 5 ☐ Other (Specifical Service License)		neado		Name and Addre	1		1		_	•	_
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П			23 Part 1. Enter the dise, or com	plications that caused the	he death. Do								Approximate Interval Between	
4.	Physician		Immediate Cause (Final disease or condition	a CHRONIC (		TIV	E PULMON	ARY D	ISEASI	E			Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):								
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8/60,	icate be executed physician and s the burlal-transit	dical		<b>d</b>										
S S	certifii ding p	/Me	IF FEMALE:	23c. If yes, outcome of	f pregnancy						224	Date of del	ivon	
DOX	The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death		Ectopic pregnand Other (specify) _	СУ			230.	Date of del Month	Day Year	
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VIIal	n: The ficate f, pag										2 <b>X</b> INo	death? 1 □ Yes	2 □ No	
5	rsicial s certi lirecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:	t 2 ☐ ER/Oı	utnation	oth Oth	ner.		Check only or		Other (Co.	UNCDICE	_
DIVISION OF	g Phy terthis neral d	Ë.T	27. Manner of Death	28a. Date of Injury (Month, Day,	/ 28b.	Time of		ry at		e 5∐ Resid ld. Describe h			cify) HOSPICE	_
201	endin sath. or: Af he fur	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	1	rear)	Injury		Yes 2	□No					
<u> </u>	or Att	Certification: T	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		y - At home, fa <i>(Specify)</i>	arm, str	eet, factory, office		28	If. Location (S City or Tow	treet and Ni n, State)	umber or Ru	ural Route Number,	
ַ	pital ours a eral D		29a. Certifier X Certifying P	nysician: To the best of	my knowledg	n doot	n annurrad at the t	imo data	and place or	ad due to the	001100(0) 00	d mannar a	n atatad	
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as	Medical		niner: On the basis of and manner state	examination ar									
	To the within To the Comp	Me	29b. Signature and title of certifier				29c. Licens	se number		- 1			h, Day, Year)	
	7		1 /2				DY	372	25		7/2	23/0	08	
	5		30. Name and address of person who								_			
		to	DR. TARIQ MAHMOOD  31. Date filed (Month, Day, Year)					[MON]	LUM, M	D 21093	3		~	
	Sta Registr		JUL 2 4 20	108 Januar	's Signature	50	rest.							
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DHMH 17 Rev 1/2001

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JULY 22,

RUTH DUDZAK

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State of Maryland /	Department of He	ealth and Menta	al Hygien

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Physiciar		edistrar  Decedent's Name (First, Middle, Last)  2. Date of Death  Month Day Year  A 20 bro
edical Examin	er	Khia Edgerton July 21, 2008 01201118
استر	4	a. Facility Name (if not institution, give street and number)  Good Samaritan Hospital  4b. City, Town, or Location of Death Baltimore
Funeral	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		218-92-1810 1 M 2 F 29 Yrs. Months Days Hours Min. 10-19-78 Country) MD
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AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show any maric event, the Medical Examiner must be notified at once.	Director	10e. Street and Number  10f. Zip Code  10g. Citizen of What Country?  USA
ath with the items 23a o		11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc.)  14. Race - American Indian, Black, White, etc.
er death	리	1 Never Married 2 Married 1 Yes 2 No Specify: Armed Forces? 1 Yes 2 No Specify: Specify: Specify: Specify:
urs aftural"	황	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
36 in 72 ho han "na lical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)
21215-0036 uld be filed within 7 Mental Hygiene. marked other thar	탕	17. Father's Name (First, Middle, Last)
1215 d be fill lental H arked	B B	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, Sta., Zip Code) 2/13
sho and and and and and	۴	Juanita Edgerton 19701 Branchleigh Road Apt. 2 Baltimore, MD
Ta ta ta ta		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State
Baltimore permit, Pages 1 a Department of He Important: If it injury or other t		4 Donation 5 Other Specify: Wouldon Foundation. U1-26-00
Baltimo permit, Page Department o Important: injury or oth	- 1	(1) Joseph H. Brown Jr. Funeral Home Baltimore
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death
Medical   aminer	ı	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):
1		Sequentially list conditions,  b
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause
d	Examiner	events resulting in death) Last Due to (or as a consequence of):
iO, te be executed ysician and burial - transii	Medical E	d. UNPENDED AMENDED
'60, cate be physici	Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery  23b. Was decedent pregnant in the 4 Live birth a Fetal death 3 Fetopic pregnancy Month Day Year
O. Box 68760, that the death certificate by the attending physic detached for use as the but	Physician/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year  4 Pregnant at time of death 5 Other (Specify)
Box death the atte	hysi	1 Yes 2 No 9 ✓ Unknown g Unknown
P.O. es that the igned by	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
ords, P.O. w requires that as been signed be stored by	ted	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
COF	Completed	
tal Rec cian: The certificate ector, page		25. Was case referred to medical 26.Place of Death (Check only one)
Vita hysicia this ce	To Be	examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other:  1 280 Data of Injury 2 281, Time of Injury 2 282, Injury at Work? 284, Describe how injury occurred
n of ding Pl h. After funera		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No  1 Yes 2 No
Division of Vital Records, rat or Attending Physician: The law requirers after death.  The Director: After this certificate has been sited in by the funeral director, page 2 should t	Certification:	2 Accident Investigation 2 Accident Investigation 2 See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town State)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Cert	Suicide determined (Specify) Swimming Pool 4312 Arizona Avenue, Baltimore, MD  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To the Hospital within 24 hours To the Funeral completely filler	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
F.≱ F. 8	ş	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
$\prec$		Tunal Tunhall, mo
5		30. Name an Codress of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
	tate	***
Regis		ORIGINAL
DHMH 17 Rev 1/	2001	ONOMAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** \_Month ucille Elsernad 2008 11:34 AM July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 🖺 F 220-40-9731 Director 90 2-2-1918 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. Count item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🖾 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 508 2nd Avenue SW 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White Specify: <u>ک</u> 3 X Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Residence Own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fil of Health and Mental H fitem 27 is marked ott Vernon M. Jett Ann M. Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. William D. Elseroad / son 212 Mountain Road; Linthicum, MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 iment of H tant: If iter 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, MD 4 ☐ Donation \_\_5 ☐ Other (Specify) Meadowridge Memorial 7-28-2008 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Frieral Service Docensee Services; 1 2nd Ave SW; Glen Burnie, MD 21061 relies 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final anronic obstructive Lung **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed Cerebrovascular physician and the burial-trans Due to (or as a consequence of) Box 68760, CENTRICATE Physician/Medical attending p as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a 1 ☐ Yes 2 PNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ■ No 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of death? page 2 s has performed' certificate Division of Vital OMPLICATIONS 2 No 1 ☐Yes 2 ☐ No 1 TYes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. June 4 2008 unknown 1 E 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 No 2 Accident Victim of house fire 3 ☐ Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State)
508 710 Avenue, Glen Burnie, determined 4 Homicide residence The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Image: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 035763 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grace A. Cordts Baltimore, Mary land Wiew Cr. 5505 Hopkins Bal

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 2 4 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- State of Maryland Registrar	d / Depa <i>Cer</i>	artment of H	lealth and l Death		Reg. No.	23813
	ician dical niner	Decedent's Name (First, Middle, Last)     Felix Faulkner  4a. Eaçility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Deat	July	Day Yea	108/608PM
Funer Directo	al	5. Social Security Number 6. Sex 7. Age (In yrs. ia 127-40-6642 72	ast birthday) Yrs.	Rith If Under 1 Year Months Days	MO R C  If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July 1	y Year) 9. V	Birthplace (State or Foreign Country) 'irginia
Maryland f show	jo	Usual Residence of Decedent  10a. State 10b. County 10c. City,  MD	Town or Lo	cation imore				10d. Inside City Limits  t☐ Yes 2 ☐ No
ith with the 23a or 28a-	Funeral Director	10e. Street and Number 2121 Windsor Garden Lane #413	Dare	10f. Zip Code	1207		10g. Citizen of What	Country?
(1 Z 13-UUSO within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at	by Fune	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2X No	dispanic Origin? (S an, Mexican, Puerl Specity:	pecify Yes or No to Rican, etc.)	14. Race - A Black, W Specify: 1	merican Indian, /hite, etc. olack
Maryland 21215-0036 ad 2 should be filed within 72 hours after death with the Marylan lith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-1 show traumatic event, the Medical Eventher must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) unk unk	(Give	dent's Usual Occup kind of work done DO NOT use retired cab d	during most of wo	rking	16b. Kind of Busine	portation
yland 2 ould be filed v Mental Hygie varked other hatto event, to	To Be Co	17. Father's Name (First, Middle, Last) Oscar Faulkner			18. Mother's Nar	me (First, Middle, Holemar	Maiden Sumame)	
12 5 E 2 E		19a. Informant's Name/Relationship (Type, Print)  Lawrence Harris/son		ng Address (Street	and Number or Ro	ural Route Numbe	er, City or Town, Stat	
Page nent o ant: If	à	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state	metery, cren	natory`or other plac			Baltimore	
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Of VICE Physician: r this certifica ral director, r	: To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	ER/Outpatien	IL SU DON	ner: 4 🗌 Nursing F		one dence 6 □Other (S how injury occurred	Specify)
DIVISION O  To the Hospitel or Attending Ph within 24 hours efter death.  To the Funeral Director: After th completely filled in by the funeral	Certification:	1 Natural 5 Pending (Month, Day Year)  2 Accident investigation 3 Suicide 6 Could not be determined determined	Injury me, farm, str	M 1	y at rk?  Yes 2 □ No		Street and Number o	r Rural Route Number,
To the Hospitel or within 24 hours et To the Funeral DI completely filled in	Medical Cer	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	vledge, death	n occurred at the till vestigation, in my c	me, date and place	e, and due to the urred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
To the within To the comple	Me	29b. Signature and title of certified		29c. Licens	353		July (3)	2008
77 A 1 6	State	30. Name and coress of pers in who completed cause of death (Item:  30. Name and coress of pers in who completed cause of death (Item:  30. Name and coress of pers in who completed cause of death (Item:  30. Name and coress of pers in who completed cause of death (Item:  30. Name and coress of pers in who completed cause of death (Item:  30. Name and coress of pers in who completed cause of death (Item:  30. Name and coress of pers in who completed cause of death (Item:  30. Name and coress of pers in who completed cause of death (Item:  30. Name and coress of pers in who completed cause of death (Item:  30. Name and coress of pers in who completed cause of death (Item:  30. Name and coress of pers in who completed cause of death (Item:  30. Name and coress of pers in who completed cause of death (Item:  30. Name and coress of pers in who completed cause of death (Item:  30. Name and coress of pers in who completed cause of death (Item:  31. Date filed (Month, Day, Year)  32. Registrar's Signature of the coress of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of the cores of th	23a) (Type,	Print)	althors	-, Mary	gland 21	229
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 4a,b pr dr., g881 0//23/08dhb.

Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat **Physician** 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year | /If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Wonth, Day al Security Number Funeral Year) Months Hours Days 1 □ M 2 1 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Examinar must be notified at 1 ☐Yes 2 KNO Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced n and Mental Hygiene. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rant's Name/Relationship (Type. Print) 960 Department of Health a Important: If item 27 is any Injury or other tra ALTO. 21227 RON 20c. Location City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2 Approximate Interval Between Onset and Death Immediate Cause (Final THIVE FAILURE TO **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner pe execu Due to (or as a consequence of): the attending physician a the burial-Physician/Medical requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) P.O. 9 I Unknown signed by t 23e. Did tobacco use contribute to the cause of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 9 MALIGNANC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown UNDIAGNORED page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 2 No 1 🗆 Yes Division of Vital 25. Was case referred to edical examiner? 26. Place Death (Check only one) Be Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28b. Time of Injury 27. Manne Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation the Hospital or Attending atural 1 🗌 Yes 2 🗌 No hours after death. 2 Accident within 24 hours after death to the Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Cer er / heck only one) Medical npletely and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 2 000601-60. o Impleted cause of death (Item 23a) (Type, Print) 30. Name a RIVER NECK PLA # 109 BALTIMINE

DHMH 17 Rev 1/2001

State Registrar 32 Registrar's Signature

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	State of Maryland / Depa 1 - State Amend Item 24a per verb. 881,97/	rtment of Health and IV triicale of Death	ientai Hygi Re	g. No. 2008 23815
	Physicia		1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year O
	/Medic		Nora Forbes		July	9 2008 9:55 6 11
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	9	4c. County of Death Prince George's
	Secretary -		Prince George's Medical Center  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	Cheverly  If Under 1 Year   If Under 24 Hrs.	8 Date of Birth	
	Funeral Director		579-42-7493 1□M 2∏F 75 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, June 23	Year) Country) unk
	land ow It	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	eation		10d. Inside City Limits
	Mary -f sh	to	MD Prince George's Upper Man	lboro		1 □Yes 2 No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	death with the Maryland ems 23a or 28a-f show r must be notified at	a	500 N. Harriett Tubman Drive	20772		USA
	be filed within 72 hours after death with the Marylan tal Hygiene. Id other than "natural", or flems 23a or 28a-1 show or other than "advisal Examiner must be notified at	by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 🔼 No	Vas Decedent of Hispanic Origin? (Sp i Yes, specify Cuban, Mexican, Puerto ☐ Yes 2♥ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: black
2-00	72 hours after natural", or Ite dirai Examine		15. Decedent's Education 16a. Deced	ent's Usual Occupation kind of work done during most of work	unk	16b. Kind of Business/Industry unk
21215-0036	d within giene. r than " the Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+) unk unk	OO NOT use retired)		
Maryland 2	d be filed intal Hyg ed othe s event,	Be	17. Father's Name (First, Middle, Last)	unk 18. Mother's Nam	e (First, Middle, N	daiden Surname) unk
ıry	should be ind Menta i marked umatic ev	ᅀ	19a. Informant's Name/Relationship ( <i>Type. Print</i> ) 19b. Mailin	g Address (Street and Number or Rui	al Route Number,	City or Town, State, Zip Code)
	nd 2 salth ar 27 ls		Prince George's Medical Center 300	l Hospital Drive (	howar1w	MD 20785
altimore,	Pages 1 and 2 should nent of Health and Mer int: If Item 27 Is marke iny or other traumatic	7	20a. Method of Disposition 20b. Place of Disposition	Hospital Drive ( sition (Name of natory or other place)	Date	20c. Location - City or Town, State
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice Neasant S Antinony D. Seasant S B	Name and Address of Facility tate Anatomy Boar altimore, MD 212		Baltimore Street
*	4		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arre	interval between
	Physician		2.00	uctive Long	Disea	Onset and Death
1	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	phalopathe		
	LAditille	er	Se uentially list conditions if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of).	phalopathe		
	uted I Insit	mi	Cause (Disease or Injury			
ó,	ficate be executed physician and sthe burial-transit	Examin	that initiated events ' c. Due to (or as a consequence of):			
68760,	te be ysicia ne bur	edical	d			
		Med	IF FEMALE:			
O. Box	faw requires that the death certif as been signed by the attending 2 should be detached for use as	Physician/M	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
S, D	res that igned b be deta	by Pt	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tot	pacco use contribute to the cause of death?
ord	w require been sign				1 Y	es 2 No 3 Probably 4 Unknown
or Vital Records,	The ate h page	Completed			24a. Was a autops perfor 1□ Yes	
/ita	Physiclan: Th r this certificate ral director, pac	Be (	25. Was case referred to medical examiner?		th (Check only on	e)
20	this al dii	은	1 Yes 27 No Hospital: Inpatient 2 ER/Outpatien			ence 6 Other (Specify)
	ng fte	ioi	27. Manner of Death  1 ZNatural 5 ☐ Pending (Month, Day Year)  2 ☐ Abdison investigation	f 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	280, Describe no	ow injury occurred
Division	or Atten Ifter deatl Director: in by the	Certification:	2 ☐ Abcident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, str building, etc. (Specify)		28f. Location (Si City or Town	treet and Number or Rural Route Number, n, State)
1	Hospital 24 hours a Funeral stely filled	Medical Ce	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, deat and manner stated.			
	To the within 2 To the comple	Mec	29b. Signature and mariner stated.	29c. License number	2	9d. Date signed (Month, Day, Year)
	->-0	1	I A WIII	DECAM		7/9/08
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	1	4 11-0
_			leng My 1 2001 Hosp	Hay DR	Chev-	er44020705
140	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  JUL 2, 4 2008  32. Registrar's Signature	edi)		J

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	•	For State Registrar	State of Marylan	(	Certificate of	Death	nentai myg R	leg. No.	08	23816
Physicia /Medic		1. Decedent's Name (First, Middle, La Marion E.	Sardner				2. Date of Deat July	<sup>D</sup> 23,	<b>Ž</b> 008	3. Time of Death 1:35 A M
Examine		4a. Facility-Name (If not institution, gi		12.3	4b. City, Town, o	r Location of Death imore cit	У	4c. County o	of Death	
Funeral Director		002-10-1235	Sex 7. Age (In yrs	. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April 2	5,1919	9. Birthpla Countr Vew H	ce (State or Foreign ampshire
/aryland f show	ō	Usual Residence of Decedent  10a. State 10b. County  MD Baltime		ity, Town o	r Location Arbutus				100	d. Inside City Limits 1 ☐ Yes 2 No
with the Na or 28a-	Direct	10e. Street and Number 5519 Rockleigh	)rive		10f. Zip Code 21227		1	10g. Citizen of What Country?  USA		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, ith Medical Evanciner must be notified at once.	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in L Armed Forces? 1   Yes 25 No If Yes, Give Year or Dates:	J.S.	13. Was Decedent of H		ecify Yes or No- Rican, etc.)			c.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or any Injury or other traumatic event, it. Medical Evann page.	npleted	15. Decedent's E(Specify only highest gr	ade completed)  College (1-4or 5+)	(6)	ecedent's Usual Occup Give kind of work done fe. DO NOT use retired	durina most of work	ing	16b. Kind of Bus		
and 21 and 21 be filed wental Hygier ed other til	Be	17. Father's Name (First, Middle, Las Arthur T. Coop		<u> </u> H	lomemaker	18. Mother's Name	e (First, Middle, I	Maiden Surname	: Home	5
, Maryll and 2 should eatth and Me n 27 Is mark er traumatic	<u>۵</u>	19a. Informant's Name/Relationship Deborah S. Ross	(Type. Print)		failing Address (Street	and Number or Rui	al Route Number	r, City or Town,		Code)
Pages 1 ar nent of Hea nnt: If Item ury or other	j	20a. Method of Disposition  Burial 2 Cremation 3 Documents of Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company Company	20b.	Place of D cemetery,	isposition (Name of crematory or other place Park Cemete	ce)	Date	20c. Location - 0	City or Tow	
Baltimo permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Lice			22. Name and Addre 1328 Sulp	ss of Facility $AMB$	ROSE FUN	VERAL HO	ME. IN	IC.
Physician /Medical		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.  Desertia	-	t enter the mode of dyir					Approximate Interval Between Onset and Death
Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consect b.							
ecords, P.O. Box 68760,  law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	al Examiner	cause (Disease of militry that initiated events resulting in death) Last	C Due to (or as a consec	quence of):						
ox 687 certificate certificate nding physise as the	/Medical	IF FEMALE:	23c. If yes, outcome of pregn	ancv				23d Dot	of deliver	. 1
P,O, BOX at the death cer by the attendin	Physician/	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	ai death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		Mor	e of deliver oth C	y Day Year
Cords, P w requires that been signed t should be deta	٥	Part II. Other significant conditions	contributing to death but not re-	sulting in th	ne underlying cause giv	en in Part I.				e cause of death?
age h	Completed						24a. Was a autops perfori	sy p med? d	Vere autoportion to come eath?	sy findings available pletion of cause of
of Vita Physiclan: r this certific	Be	25. Was case referred to medical examiner?	Hospital:		otiont 3 DOA Oth	26. Place of Deat	h (Check only on	ne)		
# # # E	٤	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Tim	ne of 28c. Injur	y at	ome 5 Reside			
isi kten deat deat ctor: y the	Certification:	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Injury - At h	Inju jome, farm	M 1 🗆	k̂? Yes 2 □ No	28f. Location (Si	treet and Numbe		Route Number,
ita		29a. Certifier 1 ☑ Certifying P	nysician: To the best of my kn	owledge, c	death occurred at the ti	me, date and place,	and due to the o	cause(s) and ma	nner as sta	ated.
To the Hi within 24 To the Fi complete	Medical	29b. Signature and title of certifier	miner: On the basis of examin and manner stated.	ation and/o	29c. Licens			date and place, a 29d. Date signed		
		Vales Both				1281		Jely 2	3 13	2008
3			completed cause of death (Ite	m 23a) (Ty #30	pe, Print) BALT	TO MD	212	29		
Stat Registra		31. Date filed (Month, Day, Year)  JUL 2 4 2008	completed cause of death (Ite	ature						

08-05469 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Norma German State of Maryland / Department of Health and Mental Hygiene 2008 23817 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 1328 hrs July 16, 2008 Medical Examiner NORA MARIE GERMAN 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Harford Edgewood 1725 Judy Way 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex **Funeral** Months oreian Min. Davs Hours Director Country) Ohio 298-54-2131 M 2XF 1954 54 June 1, Yrs Usual Residence of Decedent 10d. Inside City Limits 'n 10a State 10h County 10c. City, Town or Location Yes 2 XNo or items 23a or 28a-f show must be notified at once. Maryland Harford Edgewood Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1725 Judy Way 21040 Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with t
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a
injury or other tranmatic event, the Medicial Examiner must be not Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 Married 2 x No Yes White If Yes. Give Year Yes 2 X No specify: Specify: Widowed Divorced ģ 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Commercial Cleaning 12 Commercial Cleaner 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Orley Burton Cottrell Sr. Dana Marie McCumbers Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin Courtney German / Husband 1725 Judy Way, Edgewood, Maryland 21040 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a, Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Towson, Maryland Hilltop Service Corp. Donation 5 Other Specify 7-18-08 Signature of Juneral Service Licenses 22. Name and Address of Facility 21. McComas Funeral Home, 1317 Cokesbury Road, Abingdon. 7 Cokesbury Road. Marvland 23a. Part I. Enter the disease, or complication at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical ling physician a AMENDED UNPENDED Records, P.O. Box 68760, The law requires that the death certificate be 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months Pregnant at time of 5 Other (Specify) Yes 2 ✓ No 9 Unknown Unknown q 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Yes 2 No 3 ✔ Probably 4 Unknown Chronic Obstructive Pulmonary Disease Completed certificate has been ector, page 2 should 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 V No 2 No Yes Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Be Hospital: 1 Other<sub>4</sub> DOA Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 this ٥ 1 Yes After 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Division ✓ Natural Yes 2 death. I Director: Pendina 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) filled e Funeral determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Sig hatyre and title of certifi 29c. License number 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

July 17, 2008

Laron Locke MD.

31. Date filed (Month, Day, Year)

24

e and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	partment of Health and Nertificate of Death		giene Reg. No. 2008	23818	
	E I WE S	-	1. Decedent's Name (First, Middle, Last)	or modelo or bodin	2. Date of Dea	ıth	3. Time of Death	
	Physicia /Medic	_	JOHN SEARS GIBBS IV		JULY	20 2008	10:0Z AM	
	Examin	er	4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL	4b. City, Town, or Location of Death BALTIMORE		4c. County of Death		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdi	Months Days Hours Min.	8. Date of Birth (Month, Day 05/11/	9. Birth 1936 MAR	nplace (State or Foreign Intry) Y LAND	
	p		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits	
	Maryla f shov ied at	ō		TIMORE			1 XYes 2 No	
	th the or 28a	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?		
	ath wi	ral	412 NORTHWAY	21218		USA  14. Race - American Indian,		
_	fter de r items Iner n	Funeral	11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☐ Never Married 2 ☐ Married  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☐ Yes, Give	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Black, White	e, etc.		
200	filed within 72 hours after death with the Maryland Hylgione. ther than "natural" or items 23a or 28a-f show ant, the Medical Examiner must be notified at	þ	3 Wildowed 4 Divorced Year or Dates: OKA	1 ☐ Yes 2 X No Specify:		Specify: WH		
ה	n 72 h "natu ledical	Completed	(Specify only highest grade completed) (G	ecedent's Usual Occupation live kind of work done during most of wor le. DO NOT use retired)	king	16b. Kind of Business/l	ndustry	
7 7	d withi glene. er than the M	MO.	Elementary/Secondary (0-12) College (1-4or 5+) TE	ACHER		EDUCATION	7	
and		Be	17. Father's Name (First, Middle, Last) WILLIAM THOMAS DIXON GIBBS	18. Mother's Nam MARY M		Maiden Surname)		
I y is	should be nd Mental marked c	2		ailing Address (Street and Number or Ru			(ip Code)	
N N	1 and 2 sho Health and em 27 Is ma other trauma			2 NORTHWAY BALT	O.,MD.	21218.		
ore,	ges 1 at of He  If Item  or othe		1 Burial 2 Cremation 3 Removal from State	sposition (Name of crematory or other place)	Date	20c. Location - City or		
baltimor	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		4 □ Donation 5 □ Other (Specify) DRUID			PIKESVIL		
Ö	Depz Impo any l		Mark land	22. Name and Address of Facility HENRY W. JENKINS 16924 YORK RD MO	& SON ONKTON,	IS CO. MD. 21111	•	
	Physician	8 1	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause a each line. Immediate Cause (Final disease or condition				Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	Aten D	· 0: 10		VEARC	
		er	Se uentially list conditions in any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	2/1404 4/1	26036		- JEHRS	
٥,	ecuted nd transit	Examiner	that initiated events					
/60,	ate be executed hysician and the burial-transit	ical Ex	Due to (or as a consequence of):					
20	certificate iding phys		d					
XO 20	death certifica e attending ph ed for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of del	ivery Day Year	
5	0 0 0	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 ☐ Unknown	5 Other (specify)				
ds, r	The law requires that the dite has been signed by the age 2 should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did to	obacco use contribute to Yes 2. No 3. Pr	o the cause of death?	
ecords,	w request peen	lete	Hemodialysis a		24a. Was	an 20. Were au	utopsy findings available	
r	CG 52	Completed	Cerelynal Vascular Dis	sease	autoj perfo 1⊡ Yes	ormed? pnor to death? 2 No 1 □ Yes	completion of cause of 2 □ No	
Vital	Physician: r this certific ral director,	Be	25. Was case referr to medical examiner?	Other	th (Check only o			
ō	Phy rthis rald	7: To	27. Manuar of Death 28a. Date of New 28b. Tim	ne of 28c. Injury at		dence 6 ☐Other (Spe how injury occurred	cify)	
	ending sath. or: Aft	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No				
DIVISION	al or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (a City or To	Street and Number or Ri wn, State)	ural Route Number,	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	ledical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, one)  2 Medical Examiner: On the basis of examination and/and manner, stated.					
	To the within To the Comp	Me	29b. Signature and title of certifier	29c. License number	40	29d. Date signed (Month, Day, Year)		
	10		and the analysis of the same	me Print\	1 >	ywy a	12008	
	12		30. Name and address of person who completed cause of death (Item 23a) (Ty	7505 OSLER DRX	=306 Tou	USON MD .Z	1204	
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	sh)				

DHMH 17 Rev 1/2001

Physicia /Medic Examin
Funeral
Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in "die Erroring to the indifference."

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, <

Registrar

	1 - For State Registrar	te or Maryland	Cer	rimeni tificate	of Health and of Death	wentai ny	Reg. N	2008	23819		
ian	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	eath Da	ay Year	3. Time of Death		
cal	LUCY MAE GREEN					July	.20	2000			
ner	4a. Facility Name (If not institution, give street a.	nd number)			wn, or Location of Dea		40	County of Deal			
	SEASONS HOSPICE  5. Social Security Number 6. Sex	7. Age (In yrs. I	ast hirthday)	If Under 1	NDALLSTOWN Year   If Under 24 Hr		rth	BALTI			
	220–20–2166  Usual Residence of Decedent				Days Hours Mir		ay, Year -192	6 MA	thplace (State or Foreign ountry) RYLAND		
or	10a. State 10b. County		, Town or Loc						10d. Inside City Limits 1 X es 2 No		
rect	MD N/A	В.	ALTIMO	NE 10f. Zip C	nde		10a. C	itizen of What Co	ountry?		
Ö	602 WHITMORE AVE.			212			3	USA	<b>,</b>		
nera	11. Marital Status 12. Was	Decedent Ever in U.S	3. 13. V			Specify Yes or N	0-	14. Race - Ame	rican Indian,		
by Fu	1 □ Never Married 2 ▼ Married 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1	led Forces?  Yes 2∑No es, Give ir or Dates:		Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □Yes 2 ☑ No Specify:				Black, White			
Completed by Funeral Director	15. Decedent's Education (Specify only highest grade compl		16a. Deced (Give life. L	lent's Usual ( kind of work OO NOT use	Occupation done during most of wo retired)	orking	16b. I	Kind of Business/	Industry		
E	-12-	Elementary Good act y (6 12)									
Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	rme (First, Middle	e, Maide	n Surname)			
2	ALFRED TROWER				BERTH	A ROANE					
ľ	19a. Informant's Name/Relationship (Type. Print ARTHUR H. GREEN (HUS)				Street and Number or F						
	20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal		lace of Disposemetery, cren			Date		ocation - City or			
	4 Donation 5 Omer (Specify) ARRISON FOREST VETERANS 7-25-2008 OWINGS MILLS, MARYLAND 21. Signature of Experial Service (Specify) D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A.										
	) foratt	Hibr	1   سر	721 <b>–</b> 27	N. MONROE	ST. BAI	TIMO		YLAND 21217		
	23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death e on each line.	n. Do not ente	er the mode	of dying, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death		
	Immediate Cause (Final disease of condition resulting in death)	ERMINAL.	BLADD	ER CA	NCER				Onset and Death		
	D D	ue to (or as a consequ	ience of):								
-	Sequentially list conditions,	ue to (or as a consequ	ience of):								
i i i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events . c.										
Xal	that initiated events c resulting in death) Last	ue to (or as a consequ	ience of):								
ledical Examiner	d										
ledi											
Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	es, outcome of pregnal Live birth 2 Petal Pregnant at time of de	death 3	Ectopic pred Other (spec				23d. Date of de Month	livery Day Year		
l Š	9 □ Unknown	Unknown									
þ	Part II. Other significant conditions contributing	g to death but not resu	ılting in the ur	iderlying cau	se given in Part I.				the cause of death?		
ted						. 1	Yes 2	2 No 3 P	robably 4 Unknown		
Completed by						24a. Was auto perf	psy ormed?	prior to death?	utopsy findings available completion of cause of		
	25. Was case referred to medical				26 Place of De	1 □Yes eath (Check only	2 (N	o 1 □Yes	2 📓 No		
o Be	examiner? 1 ☐ Yes 2 ☒ No Hospital:	1 ☐ Inpatient 2 ☐ I	ER/Outpatien	t 3 🗆 DOA	Othor:	Home 5 ☐ Res		6 ⊠Other (Sne	SCHOWS		
on: T	1 ☑ Natural 5 ☐ Pending	Date of Injury (Month, Day, Year)	28b. Time of Injury	280	. Injury at Work?	28d. Describe			110SPICE		
icat	2 Accident investigation 3 Suicide 6 Could not be	Place of Injury - At ho	me form stre	M et factory o	1 □Yes 2 □No	28f Location	(Street s	and Number or P	ural Route Number,		
Certif	4 Homicide determined	building, etc. (Specify	/)	et, lactory, o		City or To			urai noute Nullibei,		
Medical Certification: To	29a. Certifier (Check only one)  1 Certifying Physician: 2 Medical Examiner: Or and	To the best of my known the basis of examinated manner stated.	wledge, death tion and/or inv	occurred at restigation, in	the time, date and pla my opinion, death oc	ce, and due to the curred at the time	e cause , date a	s) and manner and place, and due	s stated. e to the cause(s)		
Me	29b. Signature and title of certifier			29c. L	icense number			ate signed (Mont			
	I whileliorah &	ieru			H45931		Jul	y 20th.	2018		
	30. Name and address of person who completed	d cause of death (Item	23a) (Type, I	Print)	LEET RE	ISTENS7					
ate rar	31. Date filed (Month, Day, Year) JUL 2 4 2008	32 Registrar's Signat	Hre Go	whi	LEET RE						

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar 238**2**0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year D8 Physician Berdella ttines 4:01PM 07 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Oaklea Court Howara COH If Under 24 Hrs Birthplace (State or Foreign Country) 219.18.380 6. Sex 7. Age (In yrs. last birthday) If Unc 8. Date of Birth (Month, Day, **Funeral** Year) Months Days Hours Min. 1 □ M 2 💢 F 83 MD Director 03 06 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show nt of Health and Mental Hygiene.
If item 27 Is marked other than "natural", or Items 23a or 28a-f shov or other traumatic event, the Modical Event for most by notified at MD Ellicott 1 ☐ Yes 2 No Honard Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coc 9966 Vaklea USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 XNo Specify: 2 3 Vidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School System ustodian 12th grada year 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nello Benjamin Momas inomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Hicks MD 21216 Street Baltimone Baker 20a. Method of Disposition 20c. Location - City of Town, State Windsor, Mill, MD Place of Disposition (Name of King Mediorial Park permit. Page:
Department o
Important: If i
any Injury or 1 Surial 2 Cremation 3 Removal from State 26 108 Woodlawn 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility \ augun (. Greene Funeral SVC) 21. Signature of Funeral Service Licensee Jan Хh 8728 Liberty Road Randall Jown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cruse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARSIONASCULATE THEROCLEROTIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physiclan; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, attending pt IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ 100 Vital 2√ funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Yother (Specify) HSS1357 ED Medical Certification: To 1 ∐Yes 2 🖫 Vo 1 Inpatient 2 ER/Outpatient 3 DOA Division of this 28a. Date of Injury (Month, Day, Year) L) V) NG 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. ■ Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of X060160 Name and address of person who completed cause of death (Item 23a) (Type, Print) RINER NEW A # 189 201, BACIL HETERPAL 32. Registrar's Signature Zear) Day. State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year J Worth **Physician** Frederick Leo Hedrich 2:38 AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltmore
If Under 1 Year | If Under 24 Hrs. N/A nes Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Feh. 7, Social Security Number **Funeral** Hours Months Days 1 XM 2 F 214-54**-**9**5**31 50 Feb. Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Exercises must be realthed at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location N/A MD Baltimore 1X Yes 2 □ No Funeral Director 10e. Street and Number 4711 Amberley Avenue 10g. Citizen of What Country? 10f. Zip Code 21229 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 □Yes 2 🕅 No If Yes, Give Year or Dates: Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Kitchen Assistant Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kenneth Earl Hedrich Elizabeth Jane Isaac ည 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4711 Amberley Ave., Baltimore, MD 21229 19a. Informant's Name/Relationship *(Type. Print)* Kenneth E. Hedrich – Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 7-28-2008 | Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Approximate
Interval Between
Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Brain **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the burial-trar Due to (or as a consequence of): use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregrant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown à s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has r page 2 autopsy performed?/ Yes 2 No certificate 2 No 1 □ Yes

Hospital or Attending Physician: The law requires that the death certificate be execut ۵. Records,

Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manper of Death 1 ☑ Natural Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier P20556 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 900 S 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 24 E SHOW Registrar

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completely

death.

within 24 hours a

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		1 - State Registrar				<i>Ce</i>	rtificate of L	Death			.000	T	
Physici /Medi		1. Decedent's Nam	THY	2. Hf	RRis				2. Date of De Month	2.2		3. Time of Death 7:20 A M	
Examir		4a. Facility Name (		e street and nui		4b. City, Town, or Location of Death Woodbine					4c. County of Death Howard		
Funeral Director		5. Social Security N 523-32-8		Sex 1 □ M 2 <b>/√</b> F	7. Age (In yrs. I	ast birthday, Yrs.	Months Days	If Under 24 H Hours M	th y, Year) 1929	Year) Country)			
		Usual Residence o			100 Cit	, Town or L	ocation				10d Insid		
a-f show tified at	ctor	MD	10b. County Howar	d		dbine						10d. Inside City Limits 1 ☐ Yes ※XXNo	
23a or 28 Ist be no	al Director	10e. Street and Nu 1725 Ca	<sup>mber</sup> attail Wo	ods Lane	Э		10f. Zip Code 21797			-	g. Citizen of What Country? U.S.A.		
Department of Health and Mental Hygiene. Important; or Items 23a or 28a-f show Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show almortant: If Item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Mari	ried 2☐ Married 4 ☐ Divorced	12. Was Dec Armed Fo 1  Yes If Yes, Gi Year or D	<b>⊉∑</b> XNo ve	S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes XXNo	ispanic Origin? an, Mexican, Pu <i>Sp</i> ec <i>ify:</i>		14. Race - American Indian, Black, White, etc. Specify: White			
e. an "natur Medical ]	Completed	(Spe	15. Decedent's E	ducation ade completed)	1-4or 5+)	(Give	edent's Usual Occup e kind of work done o DO NOT use retired	durina most of t		of Business/In	dustry		
er th	Į.	12th				Но	memaker			Own Home			
lental Hy ked oth	To Be (	17. Father's Name Louis I	(First, Middle, Las Licht	t)					Name (First, Middle beth Tama		urname)		
alth and N 27 Is mai r traumai		19a. Informant's N Randi	lame/Relationship Blue (D	(Type. Print) aughter	)		ing Address <i>(Street</i> 25 <b>Cattai</b>						
nent of He ant: If Item ury or othe			sposition ☐Cremation 3   5 ☐ Other (Spec		Ctota	Place of Disp emetery, cre ar of	osition (Name of ematory or other place David	<sup>ce)</sup> 07	Date 7/25/2008		ation - City or T Laude:	rdale, FL	
Departr Importa any Inju		21. Signature of F	uperal Service/Ucc	la pr	A	- B	22. Name and Addre Surgee-Hen 631 Falls	ss-Seit	z Funeral Baltimore	L Home	Inc. 21211		
ysician		shock, or he Immediate Cause	art failure. List onl (Final	y one cause on	caused the deatheach line.	h. Do not er	nter the mode of dyir					Approximate Interval Between Onset and Death	
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nd ransit	Examiner	Sequentially list on any, leading to it cause. Enter Und Cause (Disease of that initiated eventials)	Infriedrate lerlying r injury ts	° H.	Heet	ensid	n					Yeary	
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cate has been signed by the attending phi page 2 should be detached for use as th	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1									3d. Date of deliv	very Day Year	
n signed b	d by Phy	A COST - TOTAL									the cause of death?		
ate has beer page 2 shou	Completed	H>	POTHY	Roidis	M		24a. Was an autopsy performe 1  Yes 2				y prior to completion of cause of death?		

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been of completely filled in by the funeral director, page 2 should

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

Hospital: 1 ☐ Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number . 30469 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N.B. VBLLANIA, 8850, CULURBIA 100 PARKUNY: #308, Columba. 31. Date filed (Month, Day, Year)

State Registrar

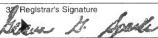
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Be

Medical Certification: To

29a. Certifier

2 4 2008



### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - For State Registrar 23823 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year SYLVIA POTTS HYATT ZOOF 20 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death LEVINDALE HEBREW HOME BALTIMORE 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Months Days Hours Min 1 □ M 2 🗶 F 03/06/1910 98 212-30-1081 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits 1 ☐ Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3517 ROCKDALE COURT 21244 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12 OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HYMAN **POTTS** ROSE GLICK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOWARD HYATT / SON 1000 SPANISH RIVER ROAD, BOCA RATON, FL 33432 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State BNAI ISRAEL CONG. 07/23/2008 BALTIMORE, MD 4□Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. emine 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) remention near Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Physician /Medical Examiner

pe

Division or Vital Records,

permit. Pages 1 and 2 st Department of Health and Important; If Item 27 is n any Injury or other traun once.

**Physician** 

/Medical

**Examiner** 

**Funeral Director** 

Completed by

Be

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**Funeral** 

Director

of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

filed within 72 hours after death with

3altimore, Maryland 21215-0036

sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit funeral director, After this

Examiner

Physician/Medical

Completed by

Be

Certification:

29a. Certifier

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

25(No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Belvedere Ave Balto Nd 21215

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 4

32. Registrar's Signature

after death Director:

within 24 hours at To the Funeral D

9

filled in by

08-0 Lilya

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ahna Hamby	4	State of Maryland / Department of Health and Mental Hygiene 2008 2382  Certificate of Death Reg. No.
	R	geristrar 2. Date of Death 3. Time of Death 3. Time of Death
Physicia dical Examin		LILYAHNA DANYELLE HAMBY July 20, 2008
th		ia. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Randallstown  Baltimore County
		Northwest Hospital
Funeral		S. Social Security Number  6. Sex  7. Age (III yis. last billings)  Months Days Hours Min.  Country) MD
Director		218-79-0564 1 M 2XF Yrs. 10 5 09/15/2007 Country/MD
any	-	Usual Residence of Decedent 10d. Inside City Limits 10d. State 10b. County 10c. City, Town or Location
		MD FREDERICK EMMITTSBURG
arylan 8a-f sl	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
vith the Maryland s 23a or 28a-f show s e notified at once.	ä	10515 TANEYTOWN PIKE 21727 USA
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s after rral",	Ē	To Dates: On Dates: On Dates: On Dates: J. 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
2 hour "nate	ğ	Elementary/Secondary (0-12) College (1-4 or 5+)
336 thin 7 ne.	ompleted	NONE NONE  18.Mother's Name (First, Middle, Maiden Surname)
5-0 led wi Hygie lother	ပ	17. Father's Name (First, Middle, Last)
21215-0036 uld be filed within 72 hou Mental Hygiene. marked other than "nat c event, the Merkel Exa	o Be	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ore, MD 21215-0036 set I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-5 sho ther traumatic event, the Markel Examiner must be notified at once	ř	MELINA M MACNER MOTHER 10515 TANEYTOWN PIKE, EMMITTSBURG, MD 21727
10re, MD 2 ages I and 2 shoul nt of Health and M nt: If item 27 is m other traumatic.		20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, Date 20c. Location - City of Town, State
MOFE Pages   nent of It annt: If i		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: WESTMINSTER CEMETERY 7/24/2008 WESTMINSTER, MD
Baltimore, permit. Pages I an Department of He Important: If ite injury or other to		21. Signature of Funeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A.
Per Per I		254 E MAIN ST WESTMINSTER, MD 21157  Approximate Interval
Physician		23a. Part I. Later the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Death  Death
aminer		Immediate Cause (Final disease or condition resulting in death)  a.Positional asphyxia  Due to (or as a consequence of):
		Sequentially list conditions, b
	ner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause
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xecuted n and   transit	cal E	M UNPENDED 23a,27,28a-f, perM,E g882, 8/20/08 TT
	edic	23d. Date of delivery
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  The this certificate has been signed by the attending physician on the Puneral Director. After this certificate has been signed by the attending physician or the puneral Director. But the purial purial purial purial director, page 2 should be detached for use as the burial	sician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
X 61 th cert ttendir r use a	cia	past 12 months?  4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
. Bo he dea y the a	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
, P.O. ires that the signed by 1		1 Yes 2 V No 3 Probably 4 Unknown
ords, w require is been sig	Completed	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
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tal Rection: The certificate ector, page	ြ	25. Was case referred to medical 26.Piace of Death (Check only one)
Vital hystcian this cert	a a	examiner?  Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other:  Nursing Home 5 Residence 6 Other:
vision of Vital Rec or Auending Phystcian: The Rer death. Therctor: After this certificate in by the funeral director, page	1. To	27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe now injury occurred
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Division of Vital Records, tal or Attending Physician: The law requir as after death.  The three of the third this certificate has been as led in by the funeral director, page 2 should it.	Certification:	2 X Accident investigation 3 Suicide 6 Could not be determined (Specify) single family residence 128e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 14 Bosley Ln. Reisterstown,
Divis Hospital or A 24 hours after Funeral Dire		
To the Hos within 24 h To the Fur	Modical	Certifying Physician: To the best of my knowledge, dearn occurred at the time, date and place, and due to the cause(s)  Check only  Check only  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To the within 2 To the complete	2	and manner stated.  29c. License number  29d. Date signed (Month, Day, Year)
		Jan Jes 14 10 O.C.M.E. July 21, 2008
lacksquare		30. Name and address of person who completed cause of death (item 23a)
NO.		Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Req	Stat	11 B & 4 (1111)   SWEARS   41 (1111)

DHMH 17 Rev 1/2001 OCME 2006

Registrar

			1 - For State Registrar		Department of Health and Certificate of Death	_	711118	23825
ľ			Registrar     Decedent's Name (First, Middle, La		Commedia or Deam	Reg. N	10.	3. Time of Death
·	Physicia /Medic	al	4a. Facility Name (If not institution, giv	Sackso	4b. Sity, Town, or Location of Dea	July 2	Pay Year 2008	641pm
) 	Examin	er 	6916 Upper 1	hills Circle	Catonsville		Bulk	٥.
	Funeral Director		013-11-3176	ET N OFF	Yrs. If Under 1 Year If Under 24 He Months Days Hours Min		(Count	ace (State or Foreign ry) and
	yland low at		Usual Residence of Decedent  10a. State  10b. County	10c, City, Towr	n or Location		10	0d. Inside City Limits
	ne Man 8a-f sh otified	Director	Md Balto	. Cato				1 ☐ Yes 2 X No
	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dieal Examiner must be notified at		10e. Street and Number	Mills Circle	10f. Zip Code 21228	10g. C	Citizen of What Count	try?
	er deat Items 2 ner mu	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pud	(Specify Yes or No- erto Rican, etc.)	14. Race - America Black, White, e	
2-0036	ours aft ral", or Exami	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ♣No Specify:		Specify: Blac	k
ה	in 72 h	oletec	15. Decedent's E (Specify only highest gr	ade completed)	Decedent's Usual Occupation (Give kind of work done during most of wellife. DO NOT use retired)		Kind of Business/Ind	ustry
7 7	filed within Hygiene. ther than "ent, the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	justodian		Education	on
and	tal d o	To Be	17. Father's Name (First, Middle, Last	con Sr	Ella.	ame (First, Middle, Maide	en Surname)	
Mary	12 should n and Mer is marke raumatic	-	19a. Informant's Name/Relationship	(Type. Print) 19b	. Mailing Address (Street and Number or	Rural Route Number, Cit	or Town, State, Zip	/ 'A
a)	s 1 and 3 of Health Item 27 other tra		20a. Method of Disposition	comete	Disposition (Name of ry, crematory or otherplace)	Date 20c.	Location - City or Tox	kd 21228 wn, State
aitimor	Pages tment of I tant: If Ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	fy) Ki wa	hem park 7-	-28-2008 B	alto. Wel	1,
g	permit. Departr Importa any inji		21. Signature of Funeral Service Lice	nsee Doulan	Name and Address of Polity	las Finero	& Service	2 P.A.
i			shock, or heart failure. List only	pplications that caused the death. Do not one cause on each line.	not enter the mode of dying, such as card	iac or respiratory arrest,		Approximate Interval Between Onset and Death
F.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CATCINOWA  Due to (or as a consequence	of Laryn	X		
	Examiner	7	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	oft:			
	cuted nd ransit	Examiner	that initiated events	c.				
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ROX	death certi e attending nd for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year
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Vitai Records	law rec as beer 2 shou	Completed				24a. Was an autopsy	24b. Were auto	psy findings available inpletion of cause of
工 高	sician: The law certificate has t irector, page 2 s		25. Was case referred to medical	T		performed 1 Yes 2 🔀	?   death?	210
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on or	th. : After the function		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Time of njury 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how in	ijury occurred	
UIVISION	or Atter after deal Director in by the	Certification:	3 Suicide 6 Could not be determined		arm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rura ate)	l Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical Co		miner: On the basis of examination ar	e, death occurred at the time, date and pland/or investigation, in my opinion, death o			
	To the within 2	Mec	29b. Signature and title of certifier	and manner stated.	29c. License number	29d. I	Date signed (Month,	Day, Year)
			I hard the le	W) Deputy	0(866)		uly 21, 2	2008
	5		Philip Mil	completed cause of death (tem 23a)	Trimble Hill	T.Zuthero	ille Md :	21093
di l	Sta Registr		31. Date filed (Month Day, Year)	7. Ragistrar's Signature	book		ŧ	

State of Maryland / Department of Health and Mental Hygiene 1- State Amend #7, perFH, G881 7/24/08 TTC ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 45 **Physician** 2008 ervard ome o 0 Ne. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltomore ( Baltmore 12, versity of If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Numberunk 7. Age (In yrs. last birthday, **Funeral** Year Days 1X M 2 □ F 58 0 MD Director Usual Residence of Decedent 10d Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Modical Examinations to notified at 1X Yes 2 No Director BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21223 1906 FAIRMOUNT AVENUE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black White, etc. 1 ☐ Yes 2 XX If Yes, Give Year or Dates: 72 hours after 1 X Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. \$ 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLOTHING 12 RETAILER 18. Mother's Name (First, Middle, Maiden Surname) Alth and Mental Hv 17. Father's Name (First, Middle, Last) Be CLARA E. BRIGGS ABRAM A. JOYNER, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 266 S. MONASTERY AVE. BALTIMORE, MD Health a CLARA W. JOYNER/SISTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 Department of Important: If it any Injury or o 1 ☐ Burial 2 😿 Cremation 3 ☐ Removal from State 7-23-2008 BALTIMORE, MARYLAND METRO CREMATORY 4 Donation 5 ☐ Other (Specify) ture of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD P. M. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Crawle disease or condition resulting in death) FA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trans and Due to (or as a consequence of) Box 68760, physician Physician/Medical the use as t IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ٥ in the past 12 months? Day 5 ☐ Other (specify) Pregnant at time of death P.O. 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown þ signed h Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page certificate t 2 No 1 □Yes ospital or Attending Physician: hours after death. funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1∭2Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No Il Director: A 2 Accident investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bathmare, MD Hirshon Mark 31. Date filed (Month, Day 2 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 3008 0520M 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HOWARD HOWARD COUNTY GENERAL HOSPITAL COLUMBIA 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-9-1923 5. Social Security Number Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. MARYLAND 217-14-8668 84 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10b. County "natural", or items 23a or 28a-f shov 28a-f shov 1√2 Yes 2 □ No Director N/A BALTIMORE MD. 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code Pages 1 and 2 should be filed within 72 hours after death with 1 and 10 that I had Mental Hygiene.
ant If item 27 is marked other than "natural", or items 23a or 1 and 10 the traumatic event, II a Mental Examinations. 21209 USA 4024 GREENSPRING AVE. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 KJYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK Be Completed by 3 ☐ Widowed 4X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)
-12-College (1-4or 5+) FOREMAN COLUMBIA NUT & BULTS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) REBA DORSEY BENJAMIN JONES ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4024 GREENSPRING AVE. BALTIMORE, MARYLAND 21209 NORA JAKSON(SISTER) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Dispos tion 7-23-2008 1 XBurial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 5 □ Oyker (Specify) 4 ☐ Donation GARRISON FOREST VETERANS OWINGS MILLS, MARYLAND HIBNER. Name and Address of Facility ral Service L OMATHA 21. Signati PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Vause (Final disease or condition resulting in death) Analy thin MINS **Physician** tains /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 ☐Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient After this Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident s after dec. 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated

10

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

30. Name and add

29b. Signature and itle of certifier

3755 C 32. Registrar's Signature

on who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

29c. License number

29d. Date signed (Month, Day, Year)

	1. Decedent's No	ame (First, Middl						2. Date of		0.	8	2 3 8 2 3. Time of Death
cian	To W	arrie (First, Middi	To A	1157				Month	Death	ay Ye	ar J	9 '50 I
lical iner	4a. Facility Name	e (If not institution	n, give street and	d number)		4b. City, Town, o	or Location of De		40	c. County of E		0 00
		Samar,				Baltin	nore			1//A	2	
	5. Social Security	y Number	6. Sex 1 M 2 □	7. Age (In yrs	0	If Under 1 Year Months Days		in. 8. Date of (Month)	Birth Day, Year	9.	Birthpla Countr	ce (State or Forei
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Funeral Director	11. Marital Statu	s arried 2 Mar	Arme	Decedent Ever in L ed Forces? es 2 ☐ No	J.S. 13. W	as Decedent of Yes, specify Cub	Hispanic Origin? oan, Mexican, Pu	(Specify Yes or erto Rican, etc.)	No-	14. Race - A Black, W		
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	20a. Method of D				Place of Dispos	ition (Name of atory or other pla	ice)	Date	20c. L	ocation - City	y or Tow	n, State
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08-05597 Kathy Kovacsi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 23829 1- For State Certificate of Death Rea. No Registrar 3. Time of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 22, 2008 0730 hrs **Medical Examiner** Kathleen H. Kovacsi 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Glen Burnie Anne Arundel 674 Chestnut Spring Lane 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) MD Min Months Davs Hours Director 214-60-4813 1 **x** M 2 F 57 1950 SEP 1 Usual Residence of Decedent 10d, Inside City Limits 10a. State 10c. City, Town or Location Yes 2 X No MD Anne Arundel Glen Burnie death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7644 Solley Road 21060 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, 11. Mantal Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married Yes If Yes. Give Year Yes 2 X No specify: Specify: White hours after Divorced ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) be filed within 72 item 27 ls marked other than 'tranmatic event, the Medical MD 21215-0036 2 Homemaker Own Home Pages I and 2 should be filed within nent of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Nicholas Hernick Catherine Kane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irme Kovacsi - husband 7644 Solley Road, Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State tant: Metro Crematory, Inc. 7/24/2008 Baltimore, MD Other Specify Donation 5 21. Signature of Funeral Service Licensee MacNabb Funeral Home, P.A. Williams U Catonsville, 301 Frederick Road. MD Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line edical a. Hyperthermia complicating Alzheimers Disease Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and Physician/Medical physician a UNPENDED AMENDED that the death certificate be Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Month Year Live birth 3 Ectopic pregnancy Dav Fetal death Pregnant at time of death Other (Specify) 5 Yes 2 ✓ No 9 Unknown q Unknowr the Ö 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 ✔ Unknown Division of Vital Records, P. Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? 1 🗸 Yes ✓ Yes 2 Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other, DOA Nursing Home 5 Residence 6 Other: Scene Inpatient 2 FR/Outpatient 3 this ဥ 1 ✓ Yes After 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Subject exposed to high environmental FOUND Natural Yes 2 ✔ No Pending temperatures Jul 22, 2008 0730 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) Woods behind 674 Chestnut Spring Lane, Glen Burnie, determined (Specify) Woods Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of ceglifier 29c. License number July 23, 2008 O.C.M.E. 30. Name and address of per who completed cause of death (Item 23a)

Jack Titus MD.

31. Date filed (Months Day, Year) 4

111 Penn Street, Baltimore, MD 21201

Deputy Chief Medical Examiner

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 23830 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 2:00 AM KESTENBERG JULY 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CITY BALTIMORE BATIMORE SINAL HOSPITAL OF BATIMORE 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year Days Hours 1**∑** M 2□ F 86 213-30-6407 POLAND 08/24/1921 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f show ofical Examiner must be notified at 1X Yes 2 □ No N/A BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21209 **USA** 6350 RED CEDAR PLACE, APT. 401 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status and 2 should be filed within 72 hours after leath and Mental Hygiene. 1 Never Married 2 Married WHITE 1 ☐ Yes 21 No Specify Specify: Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) VICE PRESIDENT GARMENT marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) TOBA LEAH ALTFEDER KESTENBERG SAMUEL ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) , so 6350 RED CEDAR PLACE, APT.401 BALTIMORE, MD 21209 VERONICA KESTENBERG / WIFE Department of Health Important: If item 27 any injury or other trong once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition CHEVRA AHAVAS CHESED 7/23/2008 Burial 2 ☐ Cremation 3 ☐ Removal from State RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Lice 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. INTRACRANIAL Immediate Cause (Final HEMORRHAGE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to him cloth cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the death certificate be executed and I-trar Due to (or as a consequence of) burialphysician Physician/Medical the attending properties for use as as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) I ☐Yes 2 ☐ No P.O. the a H Unknown 9 Unknown ģ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? certificate 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this of Certification: To 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation

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> State Registrar

Medical

6 Could not be determined

3 Suicide

29a. Certifier (Check only

4 Homicide

29b. Signature and title of certifier

AMAN SIBBL MD

31. Date filed (Month, Day, Year) 4

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0061959

28f. Location (Street and Number or Rural Route Number, City or Town, State)

JULY

THERE, 2401 W BELLEDERE AVE, BALTIMORE

29d. Date signed (Month, Day, Year)

22, 2008

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

SINH MOSPITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State	State of Mary	/land / [	Departmer	nt of Heal	Ith and M	ental Hy	giene .	2008	23831
			Registrar			Certifica	te of Dea	aın	2. Date of De	riog. rivi	2000	
	Physici	an	Decedent's Name (First, Middle,						Month	Day	Year	3. Time of Death 9:53 P M
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	<del></del>		Upper Chesapea  5. Social Security Number		enter in yrs. last bil	rthdav) If Unde	Bel A		8. Date of Bir	th	Harford 9. Birthp	lace (State or Foreign
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(3)	yland now		10a. State 10b. County	10	oc. City, Tow	n or Location					1	0d. Inside City Limits
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an P	d be	Be C	Frank John Luc	•			ر ا	atherin	e Zame	e Sea	lincki	
22, 2 (Maryland	hould Me mark	မှ	19a. Informant's Name/Relationsh		196	o. Mailing Addres					Town. State. Zip	Code)
Z	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar pepartment of Heatth and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Frank J./Lucas			97 Mrzen	cc Doad	l, Delta	D7 1	721/		,
ن ا	Hea Hea tem		20a. Method of Disposition	11- 0	20b. Place o	of Disposition (Na ery, crematory or		-	ate		ation - City or To	wn, State
しいし Baltimore.	ages ent of it: If I		1 ☐ Burrial / 2 ☑ Cremation 4 ☐ Popation 5 ☐ Other (%)	o Linemovai itori State		op Servi		7 25		Tlor.	son, Mai	orland
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	/Medical	1	diseese or condition resulting in death)	a. Due to ( s a co	onsequence	Shoe	.kc					Shows Sdays
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g) 9	certificate Iding phys	Med	IF FEMALE:									
) XX	death ce e attend ed for use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf p 1☐Live birth 2 [	□ Fetal deatl					2:	3d. Date of delive Month	ery Day Year
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C(T) Vital	Iclan certifi ector	Be	25. Was case referred to medical examiner?	Hospital:			Other:	. Place of Death				
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1-0	ding After funer	ion	1 Matural 5 ☐ Pending	(Month, Day Y		Injury	28c. Injury at Work? 1 ☐ Yes		zau. Describe	now injury	occurred	
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\\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	or A after Direction by	Certification:	4 ☐ Homicide determi	building, etc. (	(Specify)	,,	.,,			wn, State)		
2	spital ours neral	Ö	29a, Certifier 1X Certifying	g Physician: To the best of n	ny knowledg	e, death occurre	d at the time, o	date and place,	and due to the	cause(s)	and manner as s	tated.
7	e Ho 24 h e Fu	Medical	(Check only 2 Medical I	Examiner: On the basis of ex and manner stated		nd/or investigation	n, in my opinio	on, death occurr	red at the time	, date and	place, and due t	o the cause(s)
~	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s.	Me	29b. Signature and title of certifier			2:	9c. License nui	mber			e signed (Month,	
Ol			H Lin	1000	911	>   1	DOOS	356	88	Jul	7 23,	2008
2	0		30. Name an address of person	ho completed cause of deat	th (I m 23a)			poe c		seat	i DC	, we
9	12		Leffrey A	Thompson	o MI	5 7	3el A	ir m		Yand	0 -	014
1	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Inself 1						
12	Regist	rar	JUL 2 4 20	008 , 400 .	No. of							
4	HMH 17 Rev 1/2	001										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland Department of Health and Mental Hygiene 1 per dr., 2881,0//23/08dhb Reg. No. 0 23832 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Deborah Lee Month 45 4 M οΫ́ **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Jown, or Location of Death **Examiner** 1 imore 19 easons tus ()1 CR town 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Une **Funeral** Months Hours Days 1 D M 217-56-743 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examinar must be a single. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 1 10 10 € 2 No **Funeral Director** TMORR 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number e.TH 320 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yoo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 200 Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 55H HARLYST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be eu ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) M21215 Aue M 3320 BurleiTH mes ee rathe 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ruis Ridge 21. Synature of Funeral Service License 22. Name and Address of Facility Will LIBERR 4600 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) stroke **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physiclan; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. slikle cell anomiu 4 X Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? hypertonico) 24a. Was an autopsy perform r this certificate had ral director, page 2 No 1 □Yes 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dether (Specify) No specify 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After thi funeral o 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: /
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60680 7/16/00

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

24

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thut Multur toun, MO 2113/5

3 Registrar's Signature

			For State Registrar	Pleas	e Type or Pri State of M		d / Depa	<b>delible Ink</b> artment of I rtificate of	Health	and Me	ntal Hy		-	238	333
· Mary	Physici /Medio	cal		ce Richa	rd May	m)		4b. City, Town, o	- Longtion		Date of Demonstrates	Y 17	Year		
_	Examir Funeral		Saint  5. Social Security N	umber 6		Cent	last birthday)	If Under 1 Year  Months Days	T	OW 5 0 11	. Date of Bir (Month, Da	th	Balt 9. Birti	imore  place (State ountry)	or Foreign
	Director		Usual Residence of 10a. State		1 <b>X</b> M 2□ F	71	Yrs. y, Town or Lo				pr 25	, 193	37 Penr	nsylvan 10d. Inside Ci	
	th the Mary or 28a-f sh	Director	MD 10e. Street and Nur	Howar	d		Colu	mbia 10f. Zip Code				10g. Citi	zen of What Co	1 □Yes untry?	2 <b>▼</b> No
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be natified at once.	by Funeral Director	9233 Cra  11. Marital Status  1 □ Never Marri 3 ☑ Widowed	ied 2□ Marrie	12. Was Deceder Armed Forces	:? ] No		Was Decedent of I If Yes, specify Cub 1 □ Yes 2X No			fy Yes or No can, etc.)	)-	USA  14. Race - Amer Black, White Specify: b		
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Maryland 2	buld be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name William						18. Moti	her's Name (A	1 Ste	wart			
re, Mar	f and 2 sho f Health and tem 27 Is m other traum		19a. Informant's Na  Lawrence 20a. Method of Disp	R/ May		20b. P	9233	ng Address (Street  B Crazy Consistion (Name of matory or other pla	uilt		Colum	nbia,		045	
Baltimore,	permit. Pages Department of Important: If i any Injury or once.			5 ☐ Other (Spe		e   G	22	natory or other pla 2. Name and Addre cate Anat	ess of Fac	sility Board 1	55 น	Ral	timore	Street	
60,	icate be executed hybridian and physician and the burial-transil the burial-transil transil tr	ical Examiner	23a. Part 1 Enter to shock, or hea immediate Cause disease or condition resulting in death)  Sequentially list coif any, leading to improve the cause. Enter Under Cause (Disease or that initiated events resulting in death)	nt failure. List or (Final in Inditions, Imediate Injury	b. END-S Due to (or a	ONIA	uence of):  CHROI uence of):	altimore, er the mode of dy	ng, such a	as cardiac or			Y DIS	Approximat Interval Bet Onset and	e ween Death
P.O. Box 687	that the death certific led by the attending p detached for use as t	Physician/Medica	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknown	months? ⊒No	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknowr	2 Fetal	Ideath 3[	☐ Ectopic pregnan ☐ Other (specify)	су			:	23d. Date of del Month		Year
of Vital Records, P	The law requires ate has been sigr bage 2 should be	Completed by Ph	Part II. Other signit	ficant condition	s contributing to death	but not resu	ulting in the u	nderlying cause gi	ven in Par	t I.	1 24a. Was	Yes 2[	prior to death?		Unknown
of Vit	Physician: this certific al director,	To Be	25. Was case refer examiner? 1 ☐ Yes 2 ☑	No			ER/Outpatie		ner: 4□ I		5 ☐ Resi	idence	6 □Other (Spe	cify)	
Division	or Attending ifter death. Director: After in by the funer	Certification:	27. Manner of Deet  1	n 5 Pending investiga 6 Could no determin	the		28b. Time o Injury ome, farm, str y)	Wo	iry at rk? ]Yes 2[	□No	d. Describe  f. Location ( City or To	Street an	d Number or Ru	ıral Route Nun	nber,
_	To the Hospital within 24 hours a To the Funeral C completely filled	Medical Ce	29a. Certifier (Check only one)		Physician: To the be- kaminer: On the basis and manner	of examina									s)
	To the within To the Comple	Me	29b. Signature and	title of certifier $\mathcal{A}$ . $\mathcal{J}$ .	Helon		.Δ.	29c. Licen	se number			29d. Da	te signed (Mont	h, Day, Year)	8
	Sta Registi	_	ARDALL F 31. Date filed (Mon	H Ja H	ho completed cause o		501 0		IVE	TOWSO	N, MA	3RYL	O AND 21	2014	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 23834 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 22 **Physician** 11:30 PM 2008 July Dr. Victor A. McKusick /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Towson 1055 W. Joppa Road, Apt. 528 9. Birthplace (State or Foreign Country)
Maine If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, 6 Sex **Funeral** Months Days Hours Min 1 X M 2 □ F 86 10-21-1921 220-30-5980 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Baltimore Towson MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21204 1055 W. Joppa Road, Apt. 528 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1★|Yes 2 □ No If Yes, Give Year or Dates: 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinations. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care/Medicine Medical Doctor 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Ethel Buzzell Carroll L. McKusick ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1055 W. Joppa Road, Apt. 528, Towson, MD 21204 Dr. Anne McKusick / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Parkman, Maine 08-08-2008 Pingree Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Fineral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Road, Towson, Maryland 23a. Part 1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Zmonths **Physician** SMCINDM5 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of deeth 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1√10 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28h Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Hospital or Attending Physician; The law requires that the death certificate be executed physician and the burial-tran Division of Vital Records, P.O. Box 68760,

the

death

Baltimore, Maryland 21215-0036

certificate has been signed by the attending pricector, page 2 should be detached for use as or after death.

Serial Director: After this certific filled in by the funeral director,

within 24 hours a

To the Funeral I

completely filled 20+1

and manner stated DIRECTOR,

MEDICIAL ONCOLOUY

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Tuly 23, 2008

ROSS C. DONEHOWER, WID

29b. Signature and title of gertifier

29a. Certifier

Medical

who completed cause of death (Item 23a) (Type, Print)
R, MD Johns Hopins Course Center Bettomore, MD 21287

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Pay 29 2008 Physician McMain, S.N.D. JULY Sr. Marie Τ. 7:50P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Medical Towson Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔽 F Months Hours Min 84 Yrs 578-70-3487 Director Jan. 21,1924 Maine Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show than "natural", or items 23a or 28a-f showns the Medical Examinar must be notified at Director 1 ☐ Yes 2X ☐ No Maryland Baltimore Stevenson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1531 Greenspring Valley Road 21153 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Religious Community Elementary/Secondary (0-12) College (1-4or 5+) 5+ Education Notre Dame deNamur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i an. of Health an. ⁴ Item 27 Is mark. `≈r traumatic ev Ш. McMain Mary Curran Thomas ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1531 Greenspring Valley Road Stevenson, Md. 21153 Sr. Marian Schaechtle, S.N.D. Department of Health Important: If Item 27 any injury or other the once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Ilchester, Maryland Sisters of Notre Dame:7/28/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc.Towson,Md.21204 23a. Part 1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS 2DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause Unitation that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 men 1 ☐ Yes 2 ☑ No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy 1 Tyes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number D25886 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEBAL OSLER DRIVE TOWSON. 0.5 7601 MARYLAND Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		1 - State of Maryla Registrar	Certificate of Death	Reg. No. 23836
		Decedent's Name (First, Middle, Last)		2. Date of Death  Month  Day  Year  3. Time of Death
	sician edical	Barbara Rose Mitchell		July 18, 2008 7:49 PM
	miner	4a. Facility Neme (If not institution, give street and number)	4b. City, Town, or Location of Death	
		Harford Memorial Hospital	Havre de Grace	
Fune	erai		s. last birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Direc		213-38-5401 1 M 2 XF 68		Mar. 10, 1940 Maryland
g		Usual Residence of Decedent	The Table of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Cont	10d. Inside City Limits
ylan	<b>5</b> .	10a. State 10b. County 10c. C	City, Town or Location	1X1 Yes 2 □ No
Ma Wa	용	Maryland Harford	Bel Air	
th the	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
15 will	aic	9 South Atwood Road	21014	USA
i 949 d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. sther than "naturel", or ttems 23a or 28a-f ahow	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Decify Yes or No- Decify Yes or No- Decify Yes or No- Black, White, etc.
after o	를	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 X No Specify:	Specific:
9 5-0036 72 hours aft natural, or	þ	3 Widowed 4 Divorced Year or Dates:		White
72 h	t, ire Medical	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	16b. Kind of Business/Industry
2121 2121 9d within Vgiene.	를	Elementary/Secondary (0-12) College (1-4or 5+)		Assisted Living
2 2 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	Ö	10	Caregiver	ne (First, Middle, Maiden Surname)
nd nd	Be	17. Father's Name (First, Middle, Last)		rances McDowell
Ment to West	2	Melvin George Snelling		
Maryland nd 2 should be file lith and Mental Hy 27 is marked oth	E I	19a. Informant's Name/Relationship (Type, Print)		ral Route Number, City or Town, State, Zip Code)
re, Ma s 1 and 2 s 1 Health ar	<u> </u>	Charles E. Mitchell / Spouse	9 South Atwood Road	
7-18-08 1949  Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itams 23a or 28a-f ahow	ŧ	20a. Method of Disposition  1 3 gala 2 Crefmation 3 Removal from State	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Iltimo	5	4 Departion 5 Depther (Specify)	el Air Memorial Gdn. 7-24	4-08 Bel Air, Maryland
Iti	글	21. Signature of Fune at Septem Licenses	22. Name and Address of Facility McComas Funeral Ho	ome PA
B Berr ag	any ir	VI WIKIVI V STO	50 W. Broadway, Be	el Air. MD 21014
		234. Part1. Enter the disease, or complications that caused the de	eath. Do not enter the mode of dying, such as cardiac	or respiratory arrest, Approximate
		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	4. Propelling	onset and Death
Physic /Med		disease or condition resulting in death)  Due to (or as a corn	Tourses of the	3 300
Exami		Much on	rolificative Disor	oler 1 year
	<u></u>	Sequentially list conditions, b. Due to (or as a cons		0
8	rial-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
and ecut	-tran	that initiated events c.  resulting in death) Last Due to (or as a cons	sequence of):	
68760, ilicate be executed g physicien and	ouria			
87 cate t	as the bur	d		
		IF FEMALE: 23c. If yes, outcome of pre-	nnancy	23d. Date of delivery
SARA R., cords, P.O. Box (wrequires that the death certiful been signed by the attending	letached for use a	23b. Was decedent pregnant in the past 12 mgnths?	etal death 3 Ectopic pregnancy	Month Day Year
A	sic s	In the past 12 months:  1 □ Yes 2 No 9 □ Unknown	of death 5 🗆 Other (specify)	
4RBARA IN Records, P.O. The law requires that the sate has been signed by th	Phy	9 Unknown	espetting in the underking course given in Part I	23e. Did tobacco use contribute to the cause of death?
BARBARA Ital Records, Fician: The law requires tha entificate has been signed	be d		dili si cine di di si cine di si cine di di di di cine di di di di di di di di di di di di di	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
BARBARR Vital Records, sician: The law requires the	out out	0	yfling,	1 163 2 2 1 1 0 0 1 1 1 2 1 1
	2 sh	Cardial Eine	young,	24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
R R I Bell	page 2 should		(1	performed? death? 1
BARE Vital Rec	o o	25. Was case referred to medical	26. Place of Dea	ath Check only one
<u> </u>		1 Yes 2 No nospital: 1 patient 2	ER/Outpatient 3□ DOA Other: 4□ Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)
	-		28b. Time of 28c. Injury at Work?	28d. Describe how injury occurred
月圧 ( ivision or Attending ter death. Irector: Attending ter death.	the funeral	1 √2Natural 5 □ Pending (Month, Day Feat 2 □ Accident investigation	Injury Work?  M 1 Yes 2 No	
HEI Divisio or Attendi after death.	y the	3 Suicide 6 Could not be determined 28e. Place of Injury - A	at home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
S S S S S S S S S S S S S S S S S S S	ed in by the funera	4 Homicide determined building, etc. (Sp	өслу)	Only of Fown, States
DIVISION  To the Hospital or Attandit within 24 hours after death. To that Funeral Director: AT or that Prevents Director.		29a, Certifier 1 Certifying Physician: To the best of my	knowledge, death occurred at the time, date and place	e, and due to the cause(s) and manner as stated.
Hos 24 hun Fun	ptetely fill	(Check only 2 Medical Examiner: On the basis of examiner and manner stated.	nination and/or investigation, in my opinion, death occur	urred at the time, date and place, and due to the cause(s)
thin thin the	Me.	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	8	(Whian MD	132609	7/19/08
			Norm 22a) (Time Brint)	19108 HarreDe Grace MD alo78
	1	30. Name and address of person who completed cause of death (	TO INC. KLAPOLIALIAN ST	HarreDe Grace MD 20078
	. /			
	State	22 Penistrar's S	ignature	

State of Maryland / Department of Health and Mental Hygien 2008 23837 For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 8:04PM **Physician** 2 Charles L. Moran Sr. 2008 ULY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Anne Arundel Annapolis 6. Sex 1 🖾 M 2 🗆 F If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 27,1932 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 76 MD Director 218-28-1590 Usual Residence of Decedent Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 28a-f shoy f Health and Mental Hygiene. Item 27 is marked other then "naturel", or Iteme 23a or 28a-1 ehov other traumatic event, the Medital Examinar must be notified at 1 ☐ Yes 2X No Director MT Anne Arundel Glen Burnie the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 Emerson Avenue 21061 U.S.A. death Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Deperment of Health and Mental Hyglene. Important: if item 27 is marked other the eny highry or other trainment. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 No Specity: Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Installer Telephone 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edward F. Moran Anna H. Cook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 Emerson Avenue GLen Burnie, MD 21061 Mrs. Patricia A. Moran/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) July 26, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother (Specify)Entombment 2008 Cedar Hill Cemetery Brooklyn Park, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licenses 1 2nd Avenue SW Glen Burnie, MD 21061 Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CORONARY **Physician** ARTERY DISEASE resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner tha ettending physicien end hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Division of Vital Records, page 2 should be 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No RENAU DISEASE Be Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PULMONARY GBSTRUCTINE No No 1 ☐ Yes 2 ☐ No 1 ☐ Yes After this certification 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No within 24 hours after death. To the Funeral Director; A 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 29a. Certifier 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number July 23, 2008 30. Name and address of pars who completed cause of death (Item 23a) (Type, Print) Mohit ~ cg 31. Date filed (Month, Day, Year) 8601 Veterans Hary 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Mejia Month **Physician** Milagros 03:27 M July 22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Hospidal - Bayview N/A If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)

JULY 5, 1946 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 □ M 2**X** F 121-38-1377 PUERTO RICO Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other traumatic event, it is Madical Examinar is ust be notified at 1XYes 2 □ No Director N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "now any Injury or other traumating once. 1409 BONSAL STREET 21224 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 M No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Specify: PUERTO RICAN Specify: 1X Yes 2 □ No <u>۾</u> 3 Widowed 4 Divorced HISPANIC Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOUSEWIFE 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RAFAEL MALDONADO ANDREA GALINDEZ ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HECTOR M. MEJIA, SR. / HUSBAND 1409 BONSAL STREET, BALTIMORE, MD. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DAK LAWN CEMETERY 7/24/08 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee ZILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Sepsis 2 days resulting in death) /Medical Due to (or as a consequence of): Examiner Liver End Stage Sequentially list conditions, if an leadin to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No

P.O. Box 68760, Division of Vital Records,

the Hospital or Attending Physician: The law requires that the death certificate be completely filled in by the funeral within 24 hours after death To the Funeral Director:

Be

Medical Certification: To

25. Was case referred to medical examiner?

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

determined

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

State Registrar

DHMH 17 Rev 1/2001

Johns Hapkins Hospital. 600 North Wolfe Street Baltimore Maryland Daniel Gilstrep 32 Registrar's Signature 31. Date filed (Month, Day, Year) JUL 24 2008

And Disting, MEDICAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day, Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

		For State Registrar	State of Marylar	nd / Depa <i>Cer</i>	artment tificate	of He	alth ar eath		giene Reg. No. 2	008	23839
Physic /Med Exam	ical	1. Decedent's Name (First, Middle, Last)  Ar Kood r 4  4a. Facility Name (If not institution, give str	eet and number)		M <sub>1</sub>		and Docation of I	2. Date of De Month	Day	Year 2 CCS nty of Death	3. Time of Death
Funera		The Johns Hopkins Hos  5. Social Security Number  6. Sex	7. Age (In yrs.		Baltim	ore C	ity If Under 24	Hrs. 8. Date of Bir		N/A  9. Birthpl:	ace (State or Foreign
Director show		215-45-4292	10c. Ci	ty, Town or Lo	cation			10/11	1/1939		BAGAN  Dd. Inside City Limits  1 □ Yes ※□ No
with the M 3a or 28a-f t be notifie	al Director	10e. Street and Number 7206 VALLEY COUNT			10f. Zip-Co	ode 212	208			of What Countr	
:1215-0036 within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show be Medical Examiner must be notified at	by Funeral		2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	.S. 13.	Was Deceder f Yes, specify	_	anic Ongir Mexican, F Specify:	n? (Specify Yes or No Puerto Rican, etc.)	- 14. F	Race - America Black, White, et	
21215-0036 d within 72 hours aft giene. rr than "natural", or the Medical Examir	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual ( kind of work of DO NOT use i IGINEER	done dur retired)		f working	Ī	F Business/Ind	
Maryland d 2 should be file th and Mental Hy 7 Is marked oth traumatic event,	To Be (	17. Father's Name (First, Middle, Last)  BORIS	MILI				RI	FKA	BER	DICHEV	
⊆ m		19a. Informant's Name/Relationship (Type MARIETTA BRASIAVSK) 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re	AYA / WIFE  moval from State	7206 Place of Dispo	VALLES sition (Name natory or other	of or place)	JNTRY	Date	3-3 BA 20c. Locatio	LTTMOR on - City or Tov	E, MD 21208 vn, State
Baltimore, permit. Pages 1 a Department of Her Important: If Item any Injury or othe		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	ugu	89	Name and	Address	of Facility		INSON &	ERSTOW BROS. LE, MD	, INC.
SY60, ate be executed Examiner hysician and the burial-transit	dical Examiner	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Securitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect	quence of):	ary	An	rest				Approximate Interval Between Onset and Death
Division of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be executed after death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of pregn 1  Live birth 2 Fet 4 Pregnant at time of 0 9  Unknown	al death 3	Ectopic pred Other (spec					Date of deliver Month I	ry Day Year
Records, P. he law requires that it has been signed by age 2 should be deta	þ	Part II. Other significant conditions conf	ributing to death but not re	sulting in the u	ınderlying ca	use giver	n in Part I.	23e. Did 1 🗆 24a. Was	Yes 2 ☐ No	o 3 🗀 Proba	e cause of death?  ably 4 Unknown  by findings available
tal Rec n: The law ficate has b or, page 2 s	Completed	25. Was case referred to medical	-				26 Place of	auto	psy ormed? 2 No	prior to cor death?	npletion of cause of
Division of Vital Re To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation: To Be	evaminer?	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time o Injury		Other: :. Injury a Work?	4 🗆 Nursi	ng Home 5 Resi	dence 6 🗆		
Division tal or Attending rs after death. al Director: After ed in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Specification)	fy)				City or Tov	vn, State)		l Route Number,
To the Hospital within 24 hours a within 24 hours a To the Funeral D completely filled	ledical	one) 2 Medical Examin	cian: To the best of my known: On the basis of examination and manner stated.	owledge, death ation and/or in	vestigation, ir	n my opir	nion, death	place, and due to the occurred at the time	, date and pla	ce, and due to	the cause(s)
North Wilth	M	29b. Signature and title of certifier  30. Name and address of person who cor	noleted cause of death (Ite	m 23a) (Type	1	license n	omber	,	_	$f^{22}$ ,	
S Regis	late trar	Lei Zheng 31. Date filed (Month, Day, Year)  JUI 2.4 20	32. Registrar's Signa		1. 10		6	00 North Wo	olfe St, E	Baltimore	e, MD, 21287

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death **Physician**  $A^{M}$ July 16, 2008 Oliver 11:38 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10012 Dallas Avenue Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 9, 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖔 F Jan. Director 248-80-0623 64 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinate cost by nutflied at 1 XYes 2 ☐ No Director Florida Hillsborough Tampa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4926 Anniston Circle 33647 U.S.A. by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 MiNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🕅 No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 5+ Public School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Viola Hamilton Fred Walter Jones ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau
once. Marion L. Oliver (Husband) FL 33647 4926 Anniston Circle, Tampa, 20b. Place of Disposition (Name of Pine Lawn 20a. Method of Disposition 20c. Location - City or Town, State 1K Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 7/19/08 Aiken, SC 21. Signature of Fur eral Service Licen. 22. Name and Address of Facility
Jackson-Brooks Funeral Home 126 Fairfield St. SE, Aiken, SC 29802 men 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PANCREATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of if any bearing to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year ☐ Pregnant at time of death 5 Other (specify) P.O. detached signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. \$ 1 ☐ Yes 2 1 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No certificate Division of Vital 1 □ Yes 1 □Yes 2 1 No the Hospital or Attending Physician; 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Daughter's Other: 4 Nursing Home 5 Residence 6 MOther (Specify)Residence 1 ☐ Yes 2 🖾 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 27. Manuer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐Yes 2 ☐ No death. investigation 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the I within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

america some MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D16619

WIDER MILL RD, CALVERTON MD. 20765

08-05155 John Paul Papineau Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	State of Maryland / Department of He	ealth and Mental Hygiene

Jili i auri apin		1- For State Critical Certifica	ate of Dea		IVICITE		. No.	18 2384
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)				2. Date of Death	Day Year	3. Time of Death
Aedical Examir		John Paul Papineau				July 5, 2008		0452 hrs
		Facility Name (if not institution, give street and number)     Holy Cross Hospital	1 '	, Town, or L er Spring		Death	Montgomery	
Funeral	-	5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birth		nder 1 Year	If Under	24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Bi	rthplace (State ounk
Director		1 X M 2 F 58	Yrs. Mor	nths Days	Hours	Min. Sept 30	, 1949 Forei	gn ountry)
		Usual Residence of Decedent						10d. Inside City Limits
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Aaryland 28a-f show 1 at once,	힞	MD Montgomery Sil		Zip Code		10	g. Citizen of What Cou	
or 28%	Director	3901 Blackburn Lane	1.5		20904		USA	
0036 within 72 hours after death with the Maryland iene. ter than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once.		11. Marital Status UNK 12. Was Decedent Ever in U.S.				n? ( Specify Yes or No-		rican Indian, Black,
death	Funeral	1 Never Married 2 Married 1 Yes 2 No		_		Puerto Rican, etc.)	White, etc.	
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5-00 lled wit Hygien I other the Me		17. Father's Name (First, Middle, Last)	u	nk 1	18.Mother's	Name (First, Middle, M	aiden Surname)	unk
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Media	o Be	19a. Informant's Name/Relationship (Type, Print ) 19i	b. Mailing Addr	ess (Street	and Numb	per or Rural Route Num	per, City or Town, Sta	e, Zip Code)
imore, MD 2.1 Pages 1 and 2 should ment of Health and Me lant: If item 27 is ma or other traumatic e	ř	O.C.M.E.		,		Baltimore,		
e, MD 1 and 2 sho Health and item 27 is r traumati		20a. Method of Disposition 20b. Place of	of Disposition (N		netery,	Date	20c. Location - City of	r Town, State
altimore, rmit. Pages 1 a spartment of He programs: If its jury or other ti		Burial 2 Cremation 3 Removal from State  4 Donation 5 Kingspecify: in State						
mit.		21. Signatu of uneral celicensee S. wa.e. Director				oard 655 W.		Street
	Ц	23a. First I. Enter the dijease, or complications that caused the death. Do no	Baltin	more.	MD 2	71201 rdiac or respiratory arre	st, shock, or heart	Approximate Interval
Physician /Medical		fature. List only one cause on each line.  Narcotic intoxic	cation	and co	ocain	e use		Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):						1
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ed sit	Exar	events resulting in death) Last Due to (or as a consequence or):						
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760, cate be exe physician a	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy					23d. Date of delive	ery
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Div Hospital C 24 hours al Funeral E	Certification:	4 Homicide determined (Specify)		_		5ilver S	Spring. MD	
등 전 전 전 등 6 1 전 전 전 전 1 전 6		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de Check only 1 Medical Examiner: On the basis of examination and/or	eath occurred at investigation, in	t the time, da	ate and pla	ce, and due to the caus curred at the time, date	e(s) and manner as stand place, and due to	ated. the cause(s)
To the within 2 To the complet	Medical	and manner stated.  29b Signature and title of certifier		29c. Licens			29d. Date signed (f	
	_	( ) Dec God en AD		O.C.	M.E.		July 5, 2008	
		30. Name and address of person who completed cause of death (Item 23a)	)				1	
		Laron Locke MD. Assistant Medical Examiner 11	11 Penn Stre	eet, Baltir	more, Mi	D 21201		
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DHMH 17 Rev 1/2			RIGINAL					
		INCRAE.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23842 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 6:30 AM l -2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Ritchic Baltimore osesh If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Year) 216-80-3938 Months Days Hours Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Baltimore MD 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5109012 court Rd. Randallstown, Myznez Mo-ther 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee au se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. 23a. Part1. Enter the disease, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AIDS 23 425 Due to (or as a consequence of):

80/60 Box 68760, Division or Vital Records,

**Funeral** 

Director

r 28a-f show notified at show

ral", or items 23a or Examiner must be

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Department of Health ar
Important: If item 27 is
any Injury or other trau
once.

Physician

Examiner

/Medical

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

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within 24 hours after death,	To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burit	
within 24 h	To the Ful completely	

dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Inju.) that initiated events resulting in death) Last	bDue to (or as a consect cDue to (or as a consect cDue to (or as a consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect con					
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ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Certification:	3 ☐ Suicide 6 ☐ Could not by determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fa	ctory, office	28f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
Medical	29a. Certifier  (Check only one)  1. Certifying Ph 2	nysician: To the best of my knowning: On the basis of examination and manner stated.	owledge, death occu ation and/or investiga	rred at the time, date and place ation, in my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
Ž	29b. Signature and title of certifier	01 /100	( )	29c. License number	29d. I	Date signed (Month	n, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 828

HORDWITE 31. Date filed (Month, Day, Year)

EUTAU

32 Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ma /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death City Towal, or Location of Death **Examiner** 10000 5. Social Security Num If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🗓 F Director 217-34-9885 69 Maryland Apr. 14. 1939 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene. anti- of items 23 and 28 and 28 show ant: If item 27 is marked other than "natural", or items 23a or 28a-4 show any or other traumatic event, the Medical Expression in use to notified at 1 ☐ Yes 2 XNo Funeral Director Harford Maryland <u>Joppatowne</u> 10e. Street and Number 10g. Citizen of What Country? 502 Garnett Road 21085 USA 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. þ Specify 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Public Schools Baker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Rowland Edwin Forrest Myrtle Gertrude Akehurst 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Mark Pilachowski / Son</u> <u> 1711 Abelia Rd., Fallston, MD 21047</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns. 7-24-08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Service Licensee 22. Name and Address of Facility. McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. ar 1. Ent of the isease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each heart. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 100/10 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last P.O. Box 687605 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 $\square$ Live birth 2 $\square$ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Cher (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 5 Pending investigation 1 Natural 2 Accident 1 Tyes 2 □ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, neral Director; A within 24 hours a

> State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, JUL 2

4

ss of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month/Day, Year)

			For State Registrar	State of Maryla		artment of H rtificate of I		Mental Hy	giene Reg. No. 2 (	008	23844
387	Physici		1. Decedent's Name (First, Middle, L. BERNARD A	RIDGEWAY				2. Date of De Month	Day	Year 2008	3. Time of Death
	/Medic Examin Funeral Director	1	4a. Facility Name (If not institution, gi WWELSTAY OF MA 5. Social Security Number 6. 220–21–3368	RYLAND MEDICA	s. last birthday)		NORE  If Under 24 Hrs. Hours Min.	8. Date of Bi	4c. Count	y of Death	place (State or Foreign
Н	P.		Usual Residence of Decedent		City, Town or Lo	cation		100 4	, 1970		10d. Inside City Limits
	Maryla -f shov ied at	tor	MD 10a. State 10b. County	100.0	Baltin						1 Yes 2 No
	or 28a	Funeral Director	10e. Street and Number			10f. Zip Code	-		10g. Citizen of	What Cou	ntry?
	eath w	erall	410 W. Franklin  11. Marital Status unk	Street #5A	US 13 1	Vas Decedent of H		necify Yes or No	USA 14. Ra	ce - Ameri	can Indian,
336	urs after d al", or item examiner	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2ሺ No	Specify:	o Rican, etc.)	Speci	ack, White	etc. Lack
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Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		ot 3 DOA Oth	26. Place of De				
on or	rding Phys h. : After this funeral di	tion: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigati	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injui	4 🗆 Nursing r	T	how injury occi		eity)
Divisi	al or Attending P after death. I Director: After i d in by the funera	Certification:	3 Suicide 6 Could not determine		home, farm, st cify)	reet, factory, office		28f. Location City or To	(Street and Nun own, State)	nber or Ru	ral Route Number,
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_			7777777	KLER 22	S. GA	EENE ST	BACTI	MORE	MD 2	1201	
	Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar's Sig	de de	will !					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** MARY CATHERINE REED 19, 2008 4:15 P M JULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CARROLL HOSPITAL CENTER WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2√2 F 219-74-6747 97 Director 04/03/1911 MARYLAND Usual Residence of Decedent filed within 72 hours atter death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No r 28a-f sh notified Director MD CARROLL WESTMINSTER 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 1000 WELLER CIRCLE, APT. 105 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: WHITE Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE HOME MAKER 7 other other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy. Important: If item 27 is marked othe any Injury or other transmits. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be AARON JACOB MILLER NETTIE BLANCHE WANTZ 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21158 19a. Informant's Name/Relationship (Type. Print) 1000 WELLER CIRCLE, APT 105, WESTMINSTER, MD ce of Disposition (Name of Date 20c. Location - City or Town, State CARL REED SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ALL COUNTY CREMATION 7/21/08 SYKESVILLE, MD 5 ☐ Other (Specify) 4 Donation 21. Si natura o Fraeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, E. MAIN ST., WESTMINSTER, MD 21157 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial Intarction Physician /Medical Due to (or as a consequence of): Arten Disease Examiner Coronay Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) detached 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s perform this certificate 2. No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 16521 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21784 IBRAHIM 1380 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien? 23846 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician July 22, Day 2008 Year Tassia Stratigakos 10:07 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Joseph Hospital Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | B / 15 / 1923 5. Social Security Number 216-36-5511 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 🛛 F Director Greece Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits the Madical Examiner must be notified at MD Baltimore Baltimore Director 1 ☐ Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 87 Cedar Chip Court "natural', or Itams 23a 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If itam 27 Ia marked othar than "natural", or Ita 1 ☐ Yes 2**XX**No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2CXNo Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Efstratos Maragelis Despina Triandafilakos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tassos Stratigakos / Husband 87 Cedar Chip Court Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ital
any injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State St. Demetrios Cem. 7/26/2008 Baltimore, Maryland \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myscard Physician ridden /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner inding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy jo Day Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed b Pan II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Fishlation 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Certification; To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 🗌 Inpatient 2 R/Outpatient 3□ DOA 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending after death. Diractor: Af 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a

Division of Vital Records,

Hospital or Attanding Physician: The law requires that the death certificate be executed

Box 68760.

P.O. I

with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

within 2. To tha the

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 2 4 2008

30. Name and address of person who completed rause of death (Item 23a), (Type, Print)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

130433

29d. Date signed (Month, Day, Year)

Saltimore, Ma 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23847 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 2008 July 21 9:30 p M Sanders Katherine Μ. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Overlea

| Funder 1 Year | Funder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 13, Baltimore Manor Care Overlea Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Maryland 1 M 2 F 90 212-28-0229 1918 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 28a-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Forest Hill Harford Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō USA 21050 102 Marshall Drive 'natural", or items 23a Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 TYNo Specify Specify: ģ 3 ☑ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Balt. City Schools School Teacher 5+ 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatin anona 17 Father's Name (First, Middle, Last) Bertha Getson Hugh W. Meese 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 102 Marshall Dr. Forest Hill, Md. 21050 Mrs. Mary Jane Figinski/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Md. 7-26-08 Dulanev Valley Mem. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home, 21. Signature of Funeral Service l∉icensee 1050 York Rd. Towson, Md. Part 1. En er the disease, r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Lint only one cause on each line. Approximate Interval Between 23a. Part 1. En er the disease. Immediate Cause (Final disease or condition resulting in death) **Physician** llræ /Medical Due to (or as a consequence of): **Examiner** Se puentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-translt Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ed by the detached 9 Unknown 9 Unknown signed by the 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown cate has been s , page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No certificate 1 ☐ Yes 1 🗌 Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ∠ □ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of ertifier 30. Name and address of person who completed cause of death (Item 23a)/Type, Print) Raller 560 roch 31. Date filed (Month, Day, Year) egistrar's Signature State 24 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 23848 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** July 19,  $A^{M}$ 2008 6:40 Stump /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles Waldorf Genesis Health Center Waldorf If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 🕅 F 269-09-3514 Ohio Director 92 Aug. 8, 1915 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d Inside City Limits 10b. County 1 TXYes 2 □ No Director Waldorf MD Charles 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20602 4140 Old Washington Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specity: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bess Hickey Harry W. Miffitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5307 Treefish Court, Waldorf, MDKenneth A. Stump/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Rest Haven 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donatier 5 ☐ Other (Specify) 7-26-08 Evendale, Ohio Memorial Park 22. Name and Address of Facility
T.P. White & Son 21. Signature of Funeral Service Licensee White & Sons Funeral Home Beechmont Ave., Cincinnati, OH 45230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CHRONIC 4 R.S /Medical Due to (or as a consequence of): Examiner YRO ABETES if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 2 No 9 Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ C Di 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? page 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Denising Home 5 Residence 6 Other (Specify) 1 Yes 2 400 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No after death.
Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours at To the Funeral C To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAULMETION CT WALDORF 102 ASHVINKUMAR PATTL MD State Registrar

Certificate of Death

2. Date of Death

Baitimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
8000

1. Decedent's Name (First, Middle, Last)

**Physician** Month  $A^M$ July 20, 2008 3:50 Thelma Beatrice Burrello Scott /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F Yrs April 4, 1921 Washington, DC Director 87 579-24-4540 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland | Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 U.S.A. 2405 Gaither Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Black Specify þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert L. Proctor Elizabeth Harley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn L. Tucker (Daughter) 2405 Gaither St., Temple Hills, MD 20745 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 Other (Specify) 7/30/08 Resurrection Cemetery Clinton, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Blount Funeral Services, Inc. 1632 Crittenden St., N.E. Washington, DC 20017 ennie Illnen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hente Myocardia **Physician** /Medical Examiner Otherschenter Gequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Steeding upper Gas mointer hand second an to 402 mm 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has page 2 s autopsy perform 2 No I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manny of Death 28a Date of Injury 28h Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year) D0055120 21 240 8 mi) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard talmer MD 1323 Southern Washington De Ic Junk 310 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 4 2008 Registrar

08-05223 Elwood Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

IWDDa Smith	1	State of Maryland / Department of Health and Mental Hy - For State Certificate of Death		200	08 23850						
Physician		Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Death	. No.	3. Time of Death						
Medical Examine		Elwood J Smith	Month July 7, 2008		1215 hrs						
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  8627½ Quentin Avenue Apt. B	10.7	4c. County of Dea Baltimpre Cp							
	٩.	8627½ Quentin Avenue Apt. B Parkville  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	8. Date of Birth	(MM/DD/YYYY) 9. B							
Funeral Director	-	Months Days Hours Min.		Fore	ign						
	+	216 78 1974   1XM 2F 48 Yrs.   1	Jan 2	7 1960	MD MD						
any.	<u> </u>	10a. State 10b. County 10c, City, Town or Location			10d. Inside City Limits						
Maryland 28a-f show		MD Baltimore Parkville			1 Yes 2 X No						
the Maryland a or 28a-f sh		10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	untry?						
with the Maryland us 23a or 28a-f sho or rotified at once.		8627 1/2 Quentin Ave Apt B 21234	'' Y N	USA	sisas Indias Diode						
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must be irotified at once	- I	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Signature of Married Armed Forces?) 13. Was Decedent of Hispanic Origin? (Signature of Hispanic Origin?)	Rican, etc.)	White, etc.	erican Indian, Black,						
ter de		3 Wildowed 4 Divorced If Yes 2 No specify:		Specify:	white						
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5-0036 led within 72 hours after Hyggen "an autural", other than "natural", the Medical Examiner	Completed	12 n/a Storeroom Clerk  17. Father's Name (First, Middle, Last) 18. Mother's Name	e /First Middle M	McCormic	ck Spice						
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ore, Mes I and 2 of Health If item 2		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City	or Town, State						
Page Page nent o		4 Donation 5 Other Specify: Lakeview Memorial Park 7/	23/08	Sykesvil.	le MD						
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr	- 1	21. Signature of Funeral Frise Consect 22. Name and Address of Facility  Michael J Flag 22. Name and Address of Facility  Lemmon Funeral Hor	me of Du	laney Vali	ley Inc						
	4	Michael Jariag 10 W Padonia Rd 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	Timoniu or respiratory arre	m MD 2,109 st, shock, or heart	Approximate Interval						
Physician /Medical	Į	failure. List only one cause on each line.			Between Onset and Death						
xaminer	-	Immediate Cause (Final disease or condition resulting in death)  a. Probable Cardiac Arrnythilla  Due to (or as a consequence of):									
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Sox 6876  Jeath certificat e attending phy I for use as the	١	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregn	nancy	Month	Day Year						
Box 6 death ce the attended for use	)   25	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown									
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Sion attend death. ctor:	읊	2 Accident Investigation	201 ) 11 (6		Front Bouts Number City						
Divis	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, S		Rural Route Number, City						
Division Hospital or Attent A hours after death Funeral Director:		29a. Certifier 4 Contifuer Physicians To the heat of my knowledge, death occurred at the time, date and place, an	nd due to the caus	e(s) and manner as s	stated.						
To the Hos within 24 h To the Fin	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	at the time, date	and place, and due to	the cause(s)						
To wit	ĕŀ	29b. Signature and title of certifier 29c. License number		29d. Date signed (	Month, Day, Year)						
		Panati Kerithall, MD		July 8, 2008							
7	ŀ	30. Name and aggress of person who completed cause of death (Item 23a)	MD 64654								
0		Pamela E. Sputhall, MD Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201								
Star Registra	te ar	31. Date filed (Month, Day, Year) 4 2008 32. Registrar's Signature									
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			For State Registrar	State of Ma	ryland /	Depa Ce	artment of F rtificate of I	lealth and N <i>Death</i>	lental Hy	giene, <sub>Reg. No.</sub> ¢	2008	23851
	Diam'r.		Decedent's Name (First, Middle, La	ist)					2. Date of De Month			3. Time of Death
	Physicia /Medic		John Richa		h				July	20	County of Death	5:15PM
	Examin	er		cility Name (If not institution, give street and number)  orthwest Hospital Seasons Hospice  Randallstown								^e
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last I		If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	Baltimor	place (State or Foreign ntry)
	Director		213 10 3710	1 X M 2□ F	86	Yrs.	Months Days		mber 17	, 19	21 Ma	aryland
	and ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation			_		10d. Inside City Limits
	Mary a-f sho	tor	Maryland Balti	more	Ran	ndal]	lstown				ĺ	1 □Yes 2 🙀 No
	th the	Director	10e. Street and Number				10f. Zip Code				en of What Cou	
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dies! Examines must be nofflied at	eral 1	3748 Trent Road	Tao was Based at 5		140	2113				d States	s of America
	ter de irer n	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ev Armed Forces? 1 ⊕¥es 2 □ No		13.	If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		Black, White,	
036	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	1 ∏ Yes 2 □ No If Yes, Give Year or Dates:	WWII		1 □ Yes 2 🕅 🕅	Specify:			Specify: Whi	Lte
21215-0036	72 hc 'natur	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16	(Give	dent's Usual Occup kind of work done DO NOT use retired	durina most of work	ing	16b. Kin	d of Business/In	dustry
12	within ene. than '	dmc	Elementary/Secondary (0-12)	College (1-4or 5+	)		ecker	1)		Brew	ery Indu	ıstrv
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/lar	uld be Menta arked attc ev	To B	Unknown					Mary	Binko			
dar	2 sho and is ma		19a. Informant's Name/Relationship					and Number or Rui				
e è	is 1 and 2 : of Health a item 27 is		Terry Fairbairn  20a. Method of Disposition	Son			Coundtop sition (Name of matory or other place	Court, Lu	thervil		Mary Land	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Item Statel Extended at once.		1 Donation 5 □ Other (Special Special		25/08 Owings Mills, MD 21117							
Balt	permit. Departimporti any Inj once.		21. Signature of Funeral Service Lice	nsee Over 1600	333			<sup>ss of Facility</sup> Lor ty Road,				Directors,In 21133
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	plications that caused t	he death. D							Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition			ALZ	HEIMER	DEMEN	TIA			Onset and Death
· J	/Medical Examiner		resulting in death)	Due to (or as a								
Ļ		ē	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury									
3	cuted nd ransit	Examiner	that initiated events	c								
, 0,	rificate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (or as a	consequenc	e of):						
68760,	ficate I physics the b	edical		d								
Box (	eath certif attending for use as	M/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		ath 3.Γ	☐ Ectopic pregnanc	v		2	3d. Date of deliv	*
P.O. B	the deal y the att ched for	Physician/M	in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	4 Pregnant at t			Other (specify)	,			Month	Day Year
	res that the de signed by the a l be detached f	by Pt	Part II. Other significant conditions	contributing to death but	not resulting	j in the u	nderlying cause giv	en in Part I.	23e. Did tobacco use contribute to the cause of death?			
ğ	w require been sign should b								1 🗆	Yes 2	No 3□ Pro	bably 4 Unknown
ecc	e law re has be je 2 sh	Completed							24a. Was		24b. Were aut	opsy findings available ompletion of cause of
<u>=</u>	Physician: The Is r this certificate ha ral director, page 2										death? 1 ☐ Yes	2 No
Ħ	slciar certif	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	+ 2□ FR/	Outnatio	nt 3 DOA Oth	er: A D Nursing H			On Other (Spec	ity) SASONS
0	iding Phy th. : After this funeral d	n:T	27. Manner of Death	28a. Date of Injury	/ 28b	. Time o			28d. Describe			HOSPICE
Š	endin sath. or: Af he fur	atio	1 ☑ Natural 5 ☐ Pending investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide									
Division of Vital Records,	Hospital or Atten 24 hours after death Funeral Director: tely filled in by the	Certification: To							28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C		hysician: To the best of miner: On the basis of and manner state	examination							
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	_		Nellah St	endo			1445	931		JU	14 20th	2008
	p		30. Name and address of person who					1 ST GALSTON	W MK	)		
	Sta		31. Date filed (Month, Day, Year)  JUL 2 4 2008	32. Registrar	's Signature	break	الم					
	Registr	ચા	JUL 2 4 7000	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	19							

State of Maryland / Department of Health and Mental Hygiene For State Registrar 23852 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Ε. GLADYS STEM 4:55 A M 2008 JULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CARROLL HOSPICE DOVE HOUSE CARROLL WESTMINSTER If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days Months 1 □ M 2 🗓 F 212-32-2712 Director 83 6/10/1925 MARYLAND Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it of Notice Examinat must be redilled at Director 1X Yes 2 □ No WESTMINSTER MD CARROLL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 98 N. RALPH ST. 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Specify: WHITE \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) h and Mental Hygiene. CLEANING 9 CLEANER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM R. STEM ELMIRA BROWN ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2\,1\,1\,5\,7$ 27 912 OLD WESTMINSTER PIKE, WESTMINSTER, MD Department of Health Important: If item 27 any Injury or other the once. LOUISE ZEPP SISTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State WESTMINSTER CEMETERY 7/25/08 WESTMINSTER, MD 4 ☐ Donation 5 ☐ Other (Specify)

21. Sonature of Fun ral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE PULMONERU Edeno a MONCHADIOGENIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Month Vear 5 Other (specify) P.0. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by Citemicobshuchive polmonau deseon e 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other:  $_{4\,\square\,\text{Nursing Home}}$  5  $\square$  Residence 6  $\boxtimes$  Other (Specify) HOSPICE2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A investigation filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Gollus in mo Incush-D31660C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STONER AVENUE CUPSMINSTER MARYLAND 21157 2911 THOMAS K. GALMATIM 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 23853 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician JULY **EVELYN STRONG** 2008 10:45PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1024 JOHNSVILLE ROAD **ELDERSBURG** CARROLL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Of 12/1921 Birthplace (State or Foreign Country) NE Funeral 1 □ M 2 X F Months Days Hours Min. 87 **Director** 507-01-7881 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, I'm Modes Examinar must be notified once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 □Yes 2 No Director CARROLL **EDLERSBURG** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 Funeral 1024 JOHNSVILLE ROAD USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 □ Yes 2 No ğ Specify 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RIMERMAN GITLIN **ISADORE** ROSE ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARSHALL RIMERMAN / NEPHEW 5603 GERA WAY, SYKESVILLE, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP. 07/22/2008 TOWSON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyi shock, or heart failure. List only one cause in each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): attending physician for use as the buria Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? 4 Pregnant at time of death Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 TYes Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760, filled in by the funeral director.

Baltimore, Maryland 21215-0036

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) of death (Item 23a) (Type, Print) G190 Georgeton BLD Fldersburg MD 21784

State Registrar

29a. Certifier

4

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene and Copies Are Legible.

			1 - For State Registrar		State 0	i iviai yia		Certifica			iu ivieni	•	giene Reg. No	7 11	08	238	154
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	Examir	ner	4a. Facility Name (If I	not institution, giv 140ES	ve street and nu. HCSP					TIMO			4c	. County o	of Death		
	Funeral	г	5. Social Security Nur			7. Age (In yrs	. last birt	hday) If Unde	er 1 Year			ate of Birt	th		9. Birthol	ace (State or	Foreign
w .	Director		216-40-1: Usual Residence of D	369	1 □ M <b>X</b> (X)F	65	١	rs. Months	Days	Hours	Min. (A	ate of Birt Month, Da -21-	y, Year) 1942	2		ace (State or ry) yland	
£ .	aryland show			10b. County		10c. C	ity, Town	or Location							10	d. Inside City	Limits
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5	death with the Maryland ims 23a or 28a-f show rinsst be routified at	<b>Funeral Director</b>	1802 May	field Av	T					1227				Unit	ed St	ates	
	ter de item	Ē	11. Marital Status 1 □ Never Married	1 2 Morriad	12. Was Dece Armed Fo 1 ☐ Yes	dent Ever in Urces?	J.S.	13. Was Dece If Yes, spe	edent of H ecify Cuba	lispanic Origin an, Mexican, P	n? (Specify Y Puerto Rican	es or No- , etc.)		14. Race Black	- America , White, e		
OK QS 21215-0036	ursaf al', or Exem	Š	3 ☐ Widowed 4	_	If Yes, Giv	/e		1 □Yes	2 <b>√</b> No	Specify:				Specify:	T/	hite	
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	filed v Hygie other i		17. Father's Name (Fi	irst. Middle. Last	)		IATE	edical !	irans	18. Mother's			Maidan		dical	•	
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ary	shou and N s mai	_	19a. Informant's Nam				19b.	Mailing Addres	s (Street		as T. or Rural Rou				tate, Zip	Code)	
-₹≥	and 2 ealth n 27 i		James E.	Fagan,	III - S	on	- 1	013 Lit									<sup>7</sup> 1
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f shot any injury or other traumatic event, the Marical Examinar must be notified at once.		20a. Method of Dispos		Removal from S	20b.	Place of I cemetery	Disposition (Na crematory or c	me of other plac	1	July		20c. Lo	ocation - C	City or Tov	n, State	
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	/Medical Examiner		resulting in death)		Due to (	or as a consec				75.0						L 27//	
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ANN E	death ce attendi d for use	Physician/	23b. Was decedent printhe past 12 mg	onths?	1 🗌 Live b	irth 2 Feta ant at time of	al death	3 ☐ Ectopic p		у				23d. Date Mont		y Day Yea	ar
A.O.	tt the	hys	9 Unknown		9 🗆 Unkno												
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To t	Attending Physician: r death. ector: After this certific. by the funeral director, I	Ë	27. Manner of Death		28a. Date o		28b. Tir	atient 3 DC	28c. Injury Work	4 LI Nursin	ng Home 5			6 ☐ Other y occurred			
Sior	endin sath. or: Af he fur	atio	2 Accident	Pending investigation		i, Day, Year)	Inji	M M		:? Yes 2 □ No				•			
	<b>p</b>	Certification: To	3 ☐ Suicide 6 4 ☐ Homicide	6 Could not be determined	1 28e. Place	of Injury - At ho g, etc. <i>(Specif</i>	ome, farm fy)	, street, factory	, office		28f. Lo	cation (St	treet and n, State)	d Number )	or Rural i	Route Numbe	r,
S	Hospital or 24 hours afte Funeral Dir stely filled in	<u>a</u>	29a. Certifier	Certifying Phy	ysician: To the I	est of my kno	wledge,	death occurred	at the tim	ne, date and pl	lace, and du	ie to the c	ause(s)	and man	ner as sta	ted	
	To the Hospital within 24 hours a To the Funeral с сопрlетеly filled	edical	one)		iner: On the ba and mann	sis of examina	tion and/	or investigation	, in my op	pinion, death o	occurred at the	he time, d	late and	place, an	d due to t	he cause(s)	
	Vorte Con	Σ	29b. Signature and title		enoi L.	MI	)	290	License	number 20998	2	2	_	e signed (			
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_(	9)		30. Name and address	e EPIKA	ompleted cause	of death (Iten	n 23a) (T) }	rpe, Print) CATON	AVE	BAI	LTIM	DRE.	, 1	1D -	- 21	229	9
	Stat	~	31. Date filed (Month, L	Day, Year)	<b>3</b> 2. Re	gistrar's Signa	ture	all		, ,,,,							
	Registra	ır	JUL	2 <b>3 200</b> 8	Albert	as H.	GO										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year 10:05 AMM July 2008 17 Mary Kate Tews 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Shady Grove Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) 6. Sex 1 □ M 2 😿 F 71 1937 Apr 15, 396-34-7953 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2√ No MD Gaithersburg Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20877 USA 211 Russell Avenue #39 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2X No white If Yes, Give Year or Dates: Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ administrator arts 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Mary Bourke George Henry Lorenz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 211 Russell Avenue #39 Gaithersburg, MD Thomas Tews/spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Funeral Service
Anthony Pleasant 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BREATT disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown

Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai Division of Vital Records, P.O. Box 68760, been signed by the should be detached cate has page 2 s certificate : After thi thin 24 hours after death.

the Funeral Director: Aformpletely filled in by the fun

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with to ment of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or items 23a or 2 ary or other traumatic event, the Medical Examination was be not be traumatic event, the Medical Examination was be not be made traumatic event.

permit. Pages 1 Department of H Important: If ite any injury or ot

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

Funeral Director

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Completed

Be

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Examine

Be Completed by Physician/Medical

Medical Certification: To

29b. Signatu

31. Date filed (Month, Day,

the Maryland

		24a. Was an autopsy performed?  1 \( \subseteq \text{Yes} = 2 \)  1 \( \subseteq \text{Yes} = 2 \)  24b. Were autopsy findings available prior to completion of cause of death?  1 \( \subseteq \text{Yes} = 2 \)  1 \( \subseteq \text{Yes} = 2 \)  24b. Were autopsy findings available prior to completion of cause of death?								
25. Was case referred to medical	26. Place of Death (Check onl. one)									
examiner? 1 ☐ Yes 2 No	Hospital: 1  Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home	me 5 Residence 6 Other (Specify)								
27. Manper of Death  1 Natural 5 Pending 2 Accident investigation	n (Month, Day, Year) Injury Work? M 1 □ Yes 2 □ No	d. Describe how injury occurred								
3 Suicide 6 Could not b 4 Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	nysician: To the best of my knowledge, death occurred at the time, date and place, arminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.									

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso 70250H KAPIA

29d. Date signed (Month, Day, Year) 29c. License number

WV

9715 medium WD center or 32. Registrar's Signature

State Registrar

within 2

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 23856 Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Curtis Leroy Teaque July 18. 2008 5:57 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Harford Bel Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F Director Sep. 16, 1936 Maryland 215-34-5372 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Examiner must be notified at 1 √Yes 2 No Director Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 102 Seevue Court Apt. A 21014 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 6 1 ☐ Yes 2 ☑ No Specify. Completed by filed within 72 hours 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Injury or other traumatic event, the Medical Elementary/Secondary (0-12) than College (1-4or 5+) Custodian Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be is marked P Grant (nmn) Teaque Martha Elizabeth Doyle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy A. Richardson 105 A Waldon Road, Abingdon, MD 21009
of Disposition (Name of Date 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Emory U.M.C. Cemetery 7-22-08 Street, Maryland of Fure al Service Licensee Name and Address of Facility
McComas Funeral Home, P.A.
50 W. Broadway, Bel Air, MD ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, assorting on each line. Approximate Interval Between Onset and Death Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final Vears **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lue to (or as a consequence of) Examiner Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD of person who completed cause of death (Item 23a) (Type, Print) -North

State Registrar 31. Date filed (Month, Day, Year)

JUL 2 4 2008

		-	State of State	Maryland / Depa					23857		
			Registrar  Decedent's Name (First, Middle, Last)	Ce	rtificate of De		Reg. N	.2008	3. Time of Death		
- F	sicia edic	ın al	MILDRED TAYLO	July 22 2008 6:20 PM							
Exa	mine	er	a. Facility Name (If not institution, give street and numb 3056 TioGA PKW	4	c. County of Death						
Fune	eral			Age (In yrs. last birthday)		f Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, Yea	r)   Coun	lace (State or Foreign		
Direc	tor	-	214-40-4230   Jsual Residence of Decedent	90 Yrs.			JULY 9,19	118	PA		
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the Ma 28a-f	Journe	Director	Oe. Street and Number	1 13A	10f. Zip Code		10g, C	Citizen of What Coun	( '		
th with 23a or	St De		3056 TIOGA PK	س۷	212	15		U.S.	Á.		
er dea	Tiel Tiel	Funeral	Armed Ford	ent Ever in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spec Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Americ Black, White,			
036 urs aft al"; or	Тхаш	ρ	1 Never Married 2 Married 1 Yes 2 If Yes, Give  3 Wildowed 4 Divorced Year or Dat		1 ☐ Yes 2 No	Specify:		Specify: BL	ACK		
15-0 172 hc "natur	edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupation of kind of work done during DO NOT use retired)			Kind of Business/Ind	dustry		
212 d within giene.	ille M	dmo	Elementary/Secondary (0-12) College (1-4	or 5+)	TEACHE	R		Educa	ETION		
Maryland 21215-0036 td 2 should be filed within 72 hours aft tth and Mental Hygiene. Tri is marked other than "natural", or requirestic event the Medical Evant	event,	To Be C	17. Father's Name (First, Middle, Last)		18	8. Mother's Name (	First, Middle, Maide				
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Baltimore,  Dermit. Pages 1 ar  Department of Hea  mportant: If item;	0 10		20a. Method of Disposition  1 Burial 2 □ Cremation 3 □ Removal from Si	ate	matory or other place)	7- 1/		Location - City or To			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1 - For State Registrar 23858 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day JULY **Physician** ROSE C. **III MAN** 2008 21, 3:10 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death 11 SLADE AVENUE, #210 BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12/26/1910 Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□ M 🐙 F 97 292-01-4837 Director OHIO Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE BALTIMORE 1 ☐ Yes 2 🕱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 SLADE AVENUE, 21208 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No þ WHITE Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER LAW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL. CLAYMAN SARAH TUVEI MAN ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOUIS J. ULMAN / SON 4240 BLUE BARROW RIDE ELLICOTT CITY, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If It any Injury or o 1X Burial 2 Cremation I from State 7/23/2008 BETH TFILOH CONG. 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility f Funeral Service EVINSON & BROS., INC. PIKESVILLE, MD 21208 Licen SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death on each line Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital: Other: 4 Nursing Home 5 Pesidence 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 □No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

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ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

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29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death **Physician** /JPM /Medical Town, or Location of Death 4c. County of Death Examiner og l'Himore 8. Date of Birth Month, Day, Year) If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days MC**Director** Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Funeral Director Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) Be unknown ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 South Rosedole St. Batto, Md 212 illiams Satho, Md 2122 20c. Location - City or Town, State Itusbana 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Department of Important: If It any Injury or conce. 1 Burial 2 □ Cremation 3 □ Removal from State Balto., Md ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility aughn C. Green Funeral Serv. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory Approximate Interval Between Onset and Death shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to him solution cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner bue to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician Physician/Medical attending IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy of Vital 2 No 1 Yes 2 No 1 □ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 6 Other (Sp funeral 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à determined 4 Homicide 29a, Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type Print

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2008 23 Jacy /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and nucl Examiner Ba eltimore N/A 8. Date of Birth (Month, Day, Year) MAY 2 1957 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** Days Hours Min. Months 1 X M 2 □ F Maryland 51 213-72-6705 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Marylanc 10c. City, Town or Location 10b. County 10a, State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinat must be political at 1 XYes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21230 USA 2641 Norland Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2X No If Yes, Give Year or Dates: **78–81** Specify Specify: ģ White 3 Widowed 4 Divorced I Hygiene. other than "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Heating & Elementary/Secondary (0-12) 12 College (1-4or 5+) Air Conditioning Truck Driver permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygid Important: If item 27 is marked other any Injury or other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Wingfield Barbara Marsh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Matthew Wingfield - son 2641 Norland Road, Baltimore, MD 21230 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 7/24/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee H. Cremation Society of Maryland, 299 Frederick Road, Baltimore, 21228 Hule 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death locardial Immediate Cause (Final disease or condition resulting in death) tarction **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IE EEMALE If yes, outcome of pregnancy
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 Funeral Director: After this certificately filled in by the funeral director; 26. Place of Death (Check only one) 25. Was case referred to medica Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manne Death 28a. Date of Injury (Month, Day, Year) Injury 5 Pending investigation 1 Inatural 1 □Yes 2 □No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the I the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie S who completed cause of death (Item 23a) (Type, Print) Soi and address of person

State Registrar 31. Date filed (Month, Day, Year) 2 4 2008

32 registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 3:45 AM 23 2008 homas ichae /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Center Baltinore Veterns Affaire Medical Bultimare 8. Date of Birth (Month, Day, Year) Tan. 22, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F New York 1925 131-14-1315 83 Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r items 23a or 2 iner must be no 17 Oak Shadows Court 21228 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1944–45 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🛣 No Specify. 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Store Manager Retail Sales Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Waldron Margaret Briody 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas N. Waldron Oak Shadows Court; Catonsville, Maryland 21228 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Atlantic Crematory 7/24/2008 Glen Burnie, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licens MD 21228 1630 Edmondson Avenue; Catonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Heart Physician ongestive /Medical resulting in death) Due lo (or as a consequence of): Examiner ANNO ( orange Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran and Due to (or as a consequence of) physician Physician/Medical as the attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an certificate has b autopsy perform rmeg? 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2N No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this <sup>2</sup> 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident

The law requires that the death certificate be executed P.O. Box 68760, Division or Vital Records, or Attending Physician:

death

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

ed by the a detached f 24 hours after death.

Funeral Director: A etely filled in by the fu Hospital

the

State Registrar

Medical

29b	Signatur	erand title	of certifie	er	1	2.
30.	Name an	d address	person	who com	pleted	cause

6 Could not be

determined

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29c. License number

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

2120

MI

19000

2008

Baltimore

28f. Location (Street and Number or Rural Route Number, City or Town, State)

of death (Item 23a) (Type, Print)

Small Mi) 31. Date filed (Month, Day, Year) 32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

within 24 hor To the Fune completely fi

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 23862 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month WIRTS LOUISE B. 2008 4:50 A JULY4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CARROLL GOLDEN LIVING CENTER WESTMINSTER 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dav. Year) Months Days Hours 1 □ M 2 🛛 F 219-20**-**1479 81 9/20/1926 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 27 No CARROLL SYKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4244 JIM BOWERS RD. 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 21XNo If Yes, Give Year or Dates: Specify Specify: WHITE 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SECRETARY 12 CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irvin Conrad Blum Lillian Maude Stimax 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM H. WIRTS, JR.-SON 4244 JIM BOWERS RD., SYKESVILLE, MD 21784 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) COUNTY CREMATION 7/22/08 ALL SYKESVILLE, MD 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 21. Sign sture uneral Service Licensee 254 E. MAIN ST., WESTMINSTER, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TOPIC disease or condition resulting in death) as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as a consequence resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 5 Other (specify) significant conditions contributing of death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

72 hours after

12 should be fil h and Mental F 7 is marked otl

permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is n

Baltimore, Maryland 21215-0036

/Medical

10a. State

MD

Director

Funeral

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Completed

Be

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burial-tran the as use for

that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Hospital or Attending

within 24 hours after death

To the Funeral Director:
completely filled in by the

Examine

Physician/Medical

2

Completed

Be

۴

Certification:

Medical

attending physician the ģ signed t cate has to page 2 s certificate After th funeral

9 Unknown

24a. Was an performed 1 □ Yes 2 1 No 26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No

25. Was case referred to medical 1 ☐ Yes 2 PMo 27. Manner of Death

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital:

28b. Time of

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 □Yes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, JUL 2

Signature and title of certifier

Varne and address of person who complete

Registrar's Sig

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 Month **Physician** ams Ul /Medical 4b. City Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner IER RY ec oin MARYland Health Care System If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex **Funeral** Months Hours 1 M 2□F Days 072-20-5530 Usual Residence of Decedent NEW Director 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10b. County d other than "natural", or items 23a or 28a-f show event, the Modical Examiner in ust be notified at 1XYes 2 □ No ALTIMORE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1esa Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐No 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No 21215-0036 Specify. Specify: £ Yes, Give Year or Dates: 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Georgeans sugar Occupation
George kind of work done during most of working
life. DO NOT use retired)

LOOR SWEEPEW Elementary/Secondary (0-12) College (1-4or 5+) USTOdicen permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If Item 27 Is marked other the any injury or other traumatic event, I'm once. 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be liams ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type. Print) White 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Qonation 5 ☐ Other (Specify) OWING Mills. 1 07-28-08 rison Foresi 22. Name and Address of Facility Luc 1 21. Signature of Funeral Service Licensee 4600 UBERTY 1this 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on page line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) an car 0 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and death certificate be exec Due to (or as a consequence of): burial-Box 68760. attending physician Physician/Medical the as asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ρı Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably director, page 2 should Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has certificate 2 🗆 No 1 ☐ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) / US DCC 2 No 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 1 Inpatient After this funeral of 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? Injury Hospital or Attending 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hound To the Fune completely fi Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie Name and address erson who completed cause of death (Item 23a) (Type, Print) A Maryland 32. egistrar's Signature 31. Date filed (Month, Day, Year) State 2008 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 23864 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jul 17, 2008 3:30am Edith Ambrose /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland New Hope Assisted Living Center 8. Date of Birth (Month, Day, Year) Jan 7, 1917 7. Age (In yrs. last birthday) If Under 1 Year | if Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days 1 ☐ M 2 ☐ F Months Hours ЖD 213-22-3183 Usual Residence of Decedent Director 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at Yes 2□No Allegany Cumberland MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 USA 102 Wempe Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ Specify: 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ben Franklin's Store 12 laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lula Barnes Heaps Pillon Thomas Heaps 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 Cumberland Barbara Dicken daughter 102 Wempe Drive 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7/19/2008 Sunset Memorial Park MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature Fun I Service Licen 108 Virginia Avenue: Cumberland, MD 21502 23a Part1. Effer the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner WORSENING DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transi physician and is the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical as ding IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy jo in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 PARKIN SONS DI SEA SE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature N. Quisrami mo 10064167 ress of person who completed cause of death (Item 23a) (Type, Print) N. GAISRANI 500 MEMORIALAVE. C 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 4 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene PHYS 07-10-08 CM Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** June 30, 2008 11:30 AM Alexander Marsha /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 13403 Autumn Crest Drive Mt. Airy Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Min 1 □ M 2 □ X Months Days Hours Country) Ohio 10,1964214-70-1563 43 October Director Usual Residence of Decedent Maryland 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a State 10b. County 1 □Yes Ž∏No Director Kentucky Marshall Benton filed within 72 hours after death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 42025 United States 236 Sunshine Acres Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 ☐ Yes 2 ☐ X No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important; if Item 27 is marked other tha any injury or other traumatic event, Ital once. Salon / Operator Hair 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Scott Turner Carolyn Garland ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marty Alexander / Husband 236 Sunshine Acres Road, Benton, KY 42025 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 7/4/2008 Briensburg Cemetery Benton, Kentucky 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1058110 tory Mosthe disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1009 Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a nsequence of) The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2 No P.O. the detached 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed? certificate Hospital or Attending Physician: the Funeral Director: After this certific mpletely filled in by the funeral director, Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Sister's Other: 4 Nursing Home Thesidence 6 X Other (Specify) Residence 1 Tes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours after death Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 70066132 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ness St. 5 Sleer Beltines MD 21205 Feller JUL 1 0 2008 32. Resistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Year **Physician** July 3:05 5 РΜ Rashida Allen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06-01-1946 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday 6 Sex Funeral Days Hours 1 □ M 2 🗓 F Yrs. India Director 217-45-6434 62 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, It., Wedical Exv. ill activities to cliff and once. 1 ☐ Yes 2 ☑ No Director Queen Anne's Queenstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21658 United Kingdom Be Completed by Funeral 220 Brickhouse Drive 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ី No Specify: Specify: 3 Widowed 4 Divorced Indian 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 jewelry salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lai Mohamed ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 220 Brickhouse Drive, Queenstown, MD 21658 Robert A. Allen, spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 7-7-08 Alexandria, VA Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility William 8325 Mt. Harmony Lane, Owings, MD 20736  $\mathbf{R}$ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dua to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 4 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of 29d. Date signed) (Month, Day, Year) 008 30. Name and addr 10 31. Date filed (Month, Day, Registr State JUL

DHMH 17 Rev 1/2001

Registrar

P.O. Box 68760,

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23867 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 17 Day 2008 Year **Physician** 1:30 pm Constance Elaine Baker July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 18 Bridgewell Parkway Elkton Cecil | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 11, 1944 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F Yrs. 215-40-1074 Maryland 64 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Tyes 2X No Director MD Cecil Elkton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 U.S.A. 18 Bridgewell Parkway by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent Real Estate I and 2 should be filed w lealth and Mental Hygier om 27 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roberta Laura Stine Lloyd Hildebert Shue 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau 13 Sage Drive, Elkton, MD 21921 Jeff Baker, Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cremation Direct
Service 20c. Location - City or Town, State 20a. Method of Disposition July 22, 1 ☐ Burial 2 XCremation 3 X Removal from State York, PA 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trai Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes No 24a. Was an certificate has autopsy 1∐ Yes 2∑ director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 25€No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3□ DOA 1 Inpatient 2 ER/Outpatient this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, After t or Attending death. 24 hours after death Puneral Director: filled in by Hospital

with the Maryland

filed within 72 hours after

21215-0036

Maryland

Baltimore,

6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

ne and address of person who completed cause of death (Item 23a)

State Registrar

completely

within 2.

Medical

08-05274 Jacob Blackburn Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2008 23868 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month D July 9, 2008 1216 hrs Medical Examiner Jacob Lee Blackburn 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Hospital Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Months Days Hours Director Country) 23 Jan 11 1985 MD 212-13-2058 2 F 1 XM Usual Residence of Decedent 10d. Inside City Limits any 10a. State 10b. County 10c. City, Town or Location Yes 2 X No items 23a or 28a-f show ust be notified at once. Westminster Fimore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with the Maryland timent of Health and Mental Hygiene.

Tan: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Carroll Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number <u>212 Wyndtryst Drive</u> 21158 TISA uneral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married Yes White Specify: Divorced If Yes. Give Year 1 Yes 2 X No specify: ≦ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) pleted during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Foreman Plumber Plimbing 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) <u>Mary Frances Cieri</u> <u>George Brian Blackburn</u> (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 212 Wyndtryst Drive Westminster, MD 2115

Date | 20c. Location - City or Town, State M/M George Blackburn/parents 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition timore, crematory or other place) 07/14/2008 1 Burial 2 Cremation 3 Removal from State Donation 5 Other Specify Meadow Branch Cemeterly Westminster, MD 21. Signature of Funeral Ser 27 Printer and Chapel, P.A. 21157 I 412 Washington Road Westminster, sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part I. Enter the disease, or complications that **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Electrocution Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician for use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. þ 1 Yes 2 V No 3 Probably 4 Unknown Completed Division of Vital Records, After this certificate has been a funeral director, page 2 should 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes 2 No No 26 Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 1 V Yes ٩ No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year Jul 9, 2008 28b. Time of Injury 27. Manner of Death Certification: Subject electrocuted at work 1147 hrs Natural 1 ✓ Yes 2 No Pending Director: within 24 hours after death To the Funeral Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 filled in b Suicide Could not be or Town, State) 417 South Madiera Street, Baltimore, MD determined (Specify) Townhouse / Rowhouse Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number WJL July 10, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD egistrar's Signature 31. Date filed (Month, Day, Year) 32. State Registrar ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:20A M 2008 July\_ Mary M. Bennett 5, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Lorien Mount Airy Mount Airy Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 💢 F 4, 1913 Virginia 95 April 226-14-2644 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Y☐Yes 2☐No Director Maryland | Carroll Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21771 713 Midway Drive Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🛣 No Specify: Baltimore, Maryland 21215-0036 Completed by 3 □ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Public Health College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental fitem 27 is marked o Waudy J. Mangum Hettie D. Longmire 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20882 19a. Informant's Name/Relationship (Type. Print) James W. Mangum - Brother 24124 Woodfield School Road, Gaithersburg, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: If any injury or once. 7/10/08 4 Donation 5 ☐ Other (Specify) Oak Dale Cemetery Spring Hope, N. Carolina 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 21. Signature of Fun ral Service Licensee Nosuri 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a sinsequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-tra equence of): physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 XNo 4☐Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? cate has I autopsy performed? 2 No 2 No 1 🗆 Yes certificate 25. Was case referred to medical examiner? director, 26. Place of Death Check onl one Be Assisteu Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$ Other (Specify) Living2**X** No 1 Inpatient 2 ER/Outpatient 3 DOA P this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Certification: Hospital or Attending 1 X Natural 5 Pending within 24 hours after acc.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 31. Date filed (Month, Day, Year) egistrar's Signature 1 0

DHMH 17 Rev 1/2001

Registrar

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			Registrar		Cer	lineate of t	·	2. Date of De	Reg. No.		3. Time of Death $\rho$
	nysicia	ın	1. Decedent's Name (First, Middle, Last)  GEORGE WILLIAM BLANC	HFIELD	1			July	05°	2003	21:07M
	Medic xamin	-	4a. Facility Name (If not institution, give street and number	er)			Location of Death			unty of Death	
	A COMPANY		Peninsula Regional M	edical	Cnt		Lisbury	o Data of Div		icomic	
Fu	neral	į		Age (In yrs. last	birthday) _ Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da			place (State or Foreign htry)
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houl d M	item 27 is marke other traumatic	<u>٩</u>	19a. Informant's Name/Relationship (Type. Print)				and Number or Rui				
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	nt: If item ry or othe		20a. Method of Disposition  ★FMBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	te 20b. Plac cem	e of Dispo etery, cren 15en(	sition (Name of natory or other place)  Cemeto	ce) ery 7/11	/2008		ition - City or To isend,	
panti. Departir	Important: If ite any injury or of once.		21. Signature of Funeral Service Licensee  23a. Part 1. Enter the disease, implications that caus shock, or heart failure. List hily one cause on each immediate Cause (Final)	מובבג	22	Name and Addre	ess of Facility  & HUTCH  Broad St	IISON	FUNER	AL HO	ME LLC DE 19709
			23a. Part 1. Enter the disease, mplications that caus	sed the death.	Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
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execu	physician and the burial-transit	xar	that initiated events resulting in death) Last C Due to (or	as a consequer	nce of):						***************************************
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at the	d by the a etached f	Ph	9 ☐ Unknown  Part II. Other significant conditions contributing to deat	th but not resulti	na in the u	nderlying cause gi	iven in Part I.	23e. Dio	tobacco use	e contribute to	the cause of death?
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	ificate or, pa		25. Was case referred to medical				26. Place of Dea	1 ☐ Yes ath (Check onl)			
Vslcia	r this certificate ha ral director, page 2	o Be	examiner?	oatient 2 💢 El	R/Outpatie	nt 3 □ DOA O	ther: 4  Nursing H	lome 5 ☐ Re	sidence 6	☐ Other (Spe	cify)
/ISION Of VITA Attending Physician: r death.	ter thi neral (	li i	27. Manner of Death  1 ★ Pending  28a. Date of (Month,	Injury 2 Day, Year)	8b. Time o	Wo		28d. Describ	e how injury	occurred	
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DIVISION OF al or Attending Physiatter death.	d in by	Certification: To	4 Homicide determined building	, etc. (Specify)		reet, factory, office		City or I	own, State)		
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		3	30. Name and address of person who completed cause Christophen Swyden D	of death (Item 2	23a) (Type	Print) AMNOLL	St. Sh	Visbu.	ry M	nd 2.	1801
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ORIGINAL.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 23871 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JULY 6, 2008 10:10 M **BRADY** NORA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner KENT CHESTERTOWN CHESTER RIVER MANOR 8. Date of Birth (Month, Day, Yea 5/9/1916 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2X F MD Director 92 217-30-9270 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatte event, it a Medical Experiment maters in Additional and a context traumatte. 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County Director 1 ☐ Yes 2 No MD KENT ROCK HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5753 S. HAWTHORNE AVE 21661 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify ≥ Specify: 3 Widowed 4 Divorced WHITE Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 SHIPPING SUPERVISOR CHEMICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ISAAC S. REED SUSIE FORD 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSALIE KUECHLER/DAUGHTER 5719 WALNUT ST. ROCK HALL, MD 21661 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WESLEY CHAPEL 7/10/2008 ROCK HALL, MD Funeral Service License 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Autovo Sclevotic Cardio Vascular Disease Physician > 104eavs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Ye ar Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 IGERD: HM: AChol: CKD 1 Tes 2**0** No 3 Probably 4 ☐ Unknown Completed hma: Air Borne Allevaios: Authoritis: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed?
Yes 2 No has Dementia 2 🗆 No 1 ☐ Yes 1 Tyes To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗍 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide cal 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stoddard ms hestertown, MO MO Bows 21620 100 31. Date filed (Month, Day, 32. Registra State 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year <sup>Day</sup> 2008 **Physician** JÜLY 7, 07:05A M BERNECHE ETHEL /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CHESTERTOWN KENT CHESTER RIVER MANOR If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2X F 6/26/1925 MD 83 Director 217-24-6142 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director CHESTERTOWN MD KENT 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code USA 21620 200 MORGNEC RD. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔏 No 11. Marital Status 72 hours after 1 □ Yes 2 🕅 If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □ Yes 2 □ Xo Specify. Specify: WHITE þ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CHEMICAL **SECRETARY** is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARTHA OCTAVIA WILLIAMS GEORGE CURLETT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2001 MARTINS GRANT CT. CROWNSVILLE, MD 21032 t of Health GEORGE HOPKINS/NEPHEW permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 💢 Burial 2 □ Cremation 3 □ Removal from State STILL POND, MD STILL POND 7/10/2008 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 Kun 23a. Part 1. Enter the disease, or c implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner GANGRENE Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner EMAL DISEASE be executed ERIPHERAL Due to (or as a consequence of): burial-Box 68760. physician Physician/Medical the attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No Pregnant at time of death 5 Other (specify) o the 9 Hinknown ò ۵. signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ò TYPE II DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed ALZHEIMERS DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autonsy perform certificate 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospital or Attending 1 Natural 5 Pending investigation in 24 hours after death.
the Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature, and title of certifier 0041587 7-7-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chestertown, MD 21620 Speer Rd. A. Noble, MD 122 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

strar's Signature

08-05364 John A. Bowers, Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 23874

		1- For State Registrar			Certific	cate of	Death				F	Reg. No.	<u> </u>	50	0 200
Physic e ੰ ਾl Exam		Decedent's Name (First, Midd JOHN AUGUSTA	BOWE	RS, JR.							Date of De Month July 13, 2	Day 2008	Year		Time of Death 0801 hrs
		4a. Facility Name (if not institution 19608 Yarrowsburg F		et and number)		41	o. City, Tov Knoxvil		cation of	Death			c. County of Do Washington		
Funera Directo		5. Social Security Number 726–16–3940	6. Sex		(In yrs. last bi	irthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min		,	1925	Country	ace (State or Foreign y) RYLAND
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death with the Maryland or items 23a or 28a-f show any must be notified at once.		,	SHINGT		ioc. Gity, Tow	ii oi Locatio	л	KNO	OXVI	LLE.				1	Yes 2 X No
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	o Be	JOHN A. BOWER			- 1	19b. Mailing	Address				Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Commit		NOKES		p Code)
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Baltimo permit. Page Department o Important:		21. Sign three of Furier Service	e Licensee			7606	ame and A	.aaress c	iono	Bast	-Stau	ffer	Funer	al I	Home, P.A.
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	ı	or condition resulting in death)	Due t b.	o (or as a conse	equence of):										
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Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Functor: After this certificate has been signed by the attending physician and the first of the functor of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of th	h P		litions con	tributing to death	n but not resul	Iting in the u	underlying	cause gi	ven in Pa	art I.					e cause of death?
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lex	1	30. Name and address of pers Russell Alexander N		eleted cause of d			l Penn S	Street	Baltim	ore. MI	 D 21201				
pr - 6	Stat	e 31. Date filed (Month, Day, Yea	r)	- 0	ar's Signature		2 1002	2 3 11		-,					
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ta		4a. Facility Name (if not institution, give street and	d number)	4t	. City, Tow		cation of E	Death		4c. County of De		
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Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birt	hday)	If Under 1 Months	Year Days	If Under 2 Hours	Min			reign	
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5-0036 iled within 72 Hygiene. Jother than	ပိ	17. Father's Name (First, Middle, Last)				18.		`		laiden Surname)		
2121 ould be fi Mental I marked c event,	B	Robert E. Butler  19a. Informant's Name/Relationship (Type, Print	140	h Mailian	Addess	(6)			is Pr	ice ber, City or Town, S	toto 7in/	ada)
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department leath is and Mental Hygiene. Important: If item 77 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ို	Renee Wilson Butler /		_						ing, MD 2		20de)
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876 ifficat ing phy	Ž	23b. Was decedent pregnant in the	ves, outcome of pregnancy ive birth	Feta	al death	3	Ectopic p	regnancy		23d. Date of deli	Day	Year
Box 6876: e death certificate the attending phy ed for use as the b	Physician/M		regnant at time of death	5 Oth	er (Specif)	)				1		
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ires that the signed by the detached	by F	Part II. Other significant conditions - contributi	ng to death but not resultin	ig in the ur	nderiying ca	ause give	en in Part			2 ✓ No 3		
S, P.  Iuires th  an signe  Ild be de								- 4	24a. Was a			findings available
ord aw rec as bee 2 shou	ple								autop:	sy prior	to comple	etion of cause of
<b>Rec</b> The language cate h	Completed								1 Yes		Yes	2 No
tal Records, cian: The law requirector; page 2 should	Be	25. Was case referred to medical examiner?				10	th a s. ==	heck only				
of Vital Recling Physician: The l After this certificate I funeral director, page	욘	1 ✓ Yes 2 No		outpatient Time of In		`	at Work?	Nursing Ho		Residence 6 C	other: Sce	ne
Division of Vital Records, and retaining Physician: The law required and references. After this certificate has been sided in by the funeral director, page 2 should b	ii o	27. Manner of Death 28a. I 1 Natural 5 Pending Jul	Jonth Day Year)	0 hrs			s 2 🗸 N	l Driv		o ejected durin	g collisi	ion
SiO Atten r deatl ector: by the	cati	2 Accident Investigation	Place of Injury - At home, for	arm street					Location (S	Street and Number o	r Rural Re	oute Number. City
Division pital or Attent ours after death neral Director: filled in by the	Certification:	Suicide Could not be	cify) Major Road / H		,,,,,		gi	Kilm	or Town, S er Street	tate) at Route 202, Che	everly, M	D
- ie 8 je i		29a. Certifier 1 Certifying Physician: To the	best of my knowledge, de	ath occurr	ed at the ti	me, date	and place	e, and due	to the caus	e(s) and manner as	stated.	
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the ba	asis of examination and/or iner stated.	investigati	on, in my o	pinion, d	leath occu	irred at the	time, date	and place, and due	o the cau	se(s)
To To	Me	29b. Signature and title of certifier	rei stateu.		29c. I	icense r	number			29d. Date signed	(Month, E	ay, Year)
10		tolore Clim +	2000		(	D.C.M.	.E.			July 6, 2008		
		30. Name and address of person who completed	cause of death (Item 23a)							L		
			sistant Medical Exan	niner	111 Per	n Stre	et, Balt	imore, N	/ID 2120	1		
	tate	31. Date filed (Month, Day, Year) 2008 3:	2 Registrar's Signature	Snee	the s							
Regis	men	/	A CONTRACT OF THE PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERSON AND PERS	-								

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene For

22276

Physician /Medica

Examine

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinst must be notified at ounce. Once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	T = State Registrar					Cer	tificat	e of I	Death			Reg	. No. C	000	6	200	10
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al er			on, give street and n				4b. City,	Town, or	Location	of Death			4c. Count	ty of Deat	h		
	5121 N	Newport	t Ave				Bet	hesd	la				Mont	gome:	ry		
	5. Social Security N	_	6. Sex	7. Age	(In yrs. last	birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of	Birth		9. Birt	hplace	(State or Fo	oreign
	037-38-4		<b>X</b> M 2□ F	1	5.5	Yrs.	Months	Days	Hours	Min.	June 6	Day, Y	ea <i>r)</i> 53	Was	h D	Ċ	
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λF	1 ☐ Never Marri 3 ☐ Widowed		If Yes, C	2XN Rive	O	1	□Yes	2 <b>X</b> No	Specify	:			Speci	ify: W	hit	e	
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	17. Father's Name										- '						
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10	Rose Ba	artiett	c/ wire														
	20a. Method of Disp		3 ☐ Removal fron	e Ctoto	20b. Place ceme	e of Dispos etery, crem	sition (Nar natory or o	ne of other plac	e)	[	Date	20	c. Location	- City or	Town,	State	
	4 ☐ Donation			State	Na	ation				7-9			alls		•		
	21. Signature of Fu	ineral Service	Licensee								seph (						
	► 11/1/20	ANI	YW)			5	130 W	Visco	nsin	Ave	, N.W.	. Wa	shing	ton	DC	20016	
	23a. Part 1. Enter t	he disease, or	r complications that	caused	the death. D	o not ente	er the mod	de of dyin	ig, such as	cardiac	or respirato	ry arrest	,		Apr	proximate	
	shock, or hea Immediate Cause		t only one cause on	each line	е.										On	erval Betwee set and Dea	ıth
	disease or condition resulting in death)	òn			atic I		Cance	r							0	Months	3
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xar	that initiated events resulting in death) I	; ' '	c	(or as a	consequence	ce of):											
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n/Medical Examiner			d														
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ian	23b. Was decedent in the past 12		1 Live	birth 2	2 ☐ Fetal de	ath 3 □	Ectopic p		y					ate of del fonth	ivery Day	Yea	ī
Sic	1 □ Yes 2 □ 9 □ Unknown	□No	9 □ Uni		time of deat	n 5L	Other (sp	ресіту)				-					
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BeC	25. Was case refer	red to medica	ı						26. Place	e of Deat	h (Check or		2.10				
	examiner? 1∐Yes 2∐	No	Hospital: 1	] Inpatier	nt 2□ER/	Outpatient	3 🗆 D0	Othe	er: 4 □ Ni	ursing Ho	me 5∛⊡ F	Residenc	e 6 □Ot	ther (Spe	cifv)		
اڃَ	27. Manner of Death		28a. Date			b. Time of	2	28c. Injury Work			28d. Descri			_ , ,			
읉	1 ₩ Natural 2 Accident	5 ☐ Pendin investi	19 '	nth, Day,	rear)	Injury	М		r Yes 2□	No							
Ęį	3 ☐ Suicide	6 ☐ Could determ	ninged 286. Place	e of Inju	ry - At home,	, farm, stre	et, factory	, office			28f. Location	n (Stree	t and Num	ber or Ru	ıral Ro	ute Number,	
ert	4 Homicide	dotorri	build	ding, etc.	(Specify)						City or	Town, S	(tate)				
2	29a. Certifier	1X Certifyir	ng Physician: To th	e best o	f my knowled	dge, death	occurred	at the tir	ne, date a	nd place,	and due to	the cau	se(s) and n	nanner as	state	d.	
Medical Certification: To	(Check only one)	2 Medical	Examiner: On the and ma	basis of nner stat		and/or inv	estigation	i, in my o	pinion, dea	ath occur	red at the ti	me, date	and place	, and due	to the	cause(s)	
Me	29b. Signature and	title of certifie			1	1			e number			29d	Date sign	ed (Monti	h, Day,	Year)	
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State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 23877 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Eleanor Brown June 2008 23. 1308 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2 🕅 F 92 579-40-0004 MD October 25, 1915 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Washington 1 □Xes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 635 Edgewood Street NE Apt. 714 20002 LISA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 ∐Yes 2 ⊠No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Someone Else's Home <u>Domestic</u> 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Belton Brown Susie Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susie Brown - Sister 7518 Grouse Place, Landover, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 6/28/2008 Alexandria, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diff Colitis disease or condition resulting in death) Due to (or as a consequence of): Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Malnutrition Due to (or as a consequence of): Dementia IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

the death certificate be executed

The law requires that

Physician: After this certific

or Attending

Hospital

To the

dRW 2

Box 68760,

P.O. I

Records,

Division of Vital

Department of H Important: If ite any injury or ot once.

**Physician** 

/Medical

Examiner

10a. State

DC

**Funeral** 

Director

28a-f show

Pages 1 and 2 should be filed within 72 hours after death with term of Healith and Mental Hyglene.
ant: If liem 27 is marked other than "natural", or items 23a or :
ury or other traumatic event, I'm Muchal Event inc. 1181 ben

Baltimore, Maryland 21215-0036

Evaniner must be notified at

Director

Funeral

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Completed

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the Maryland

ending physician and use as the burial-tran attending p for use as signed by the a icate has been si

Examiner Physician/Medical à Completed Be Certification: To within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

25. Was case referred to medical examiner? 27. Manner of Death

ical

☐Yes 2 No 9 Unknown

1 Yes 2 No

1 Natural

2 Accident

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown

autopsy performed? Yes 2. No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

24a Was an

24b. Were autopsy findings available prior to completion of cause of death? 2 □ No 1 □ Yes

6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

28a. Date of Injury (Month, Day, Year)

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

29b. Signature and title of certifier 30. Name and address of person who completed cause of deat (Herri 23a) (Type, Print)

5 ☐ Pending investigation

Hospital:

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

Wagner andal 31. Date filed (Month, Day, -Year

JUL

32. Registros Signature 2008

7600 Carroll Ave. Takoma Park, MD 20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#2perPHYS, G884, 10/28/08, WS

Amend Items 23art 1,25,27,28a-1 per me. g882,08/29/08dib

Certificate of Death

Reg. NO. 2008 23878 Reg. No 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 7 , 2008 Dilliam **Physician** Month July Day Bramble 815 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Kiver Ituspital Center hestertour If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 XM 2 ☐ F Director 213-22-9243 11/07/1926 MD Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 X Yes 2 □ No QUEEN ANNE'S CRUMPTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 important: If item 27 is marked other than "natural", or items 23a or 2 and y Injury or other traumatic event, the Medical Examiner must be none. 218 SECOND ST. 21628 Funeral USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) JANITOR AUTOMOTIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM MAXWELL BRAMBLE MARIE EDWARDS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEAN L. BRAMBLE/WIFE 218 SECOND ST. PO BOX 144 CRUMPTON, MD 21628 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CRUMPTON CEMETERY 7/11/2008 CRUMPTON, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 370 W. CYPRESS ST. MILLINGTON, MD 21651 20a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he dialiure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VISCOUS PERFORATED MAD ROVED BY MEDICAL EXAMINER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any line of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed CERTIFIC Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> TYPE 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed DISEASE RKINSONS 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy PECENT HIP FRACTURE performed 1□ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred Subject fell while attempting to pick up lounge chair. 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 5:50p. M 06/0172008<sup>(1)</sup> 1 ☐ Yes 2 No 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 218 Second Street, Crumpton, MD 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Home 24 hours a Euneral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 hor To the Fune completely f (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m s NOBLE 122 SPEER RD CHESTERTOWN 21620 31. Date filed (Month, Day, Year) 32. Registar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23879 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 2008 22:20 Crites JULY 16 Donald /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** ALLEGANY CUMBERLAND MEMORIAL HOSPITAL 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year May 22, 19 If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours ¥ M 2□F 1936 Director 220-32-44()4 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County a or 28a-f show t be notified at Y□Yes 2□No Oldtown Allegany MD **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 21555 USA 14114 Cresap Mill Road "natural", or Items 23a 12. Was Decedent Ever in U.S. Armed Forces?

★□ Yes 2□ No if Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify: Completed by white 3€ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Monee. local teamsters 12 truck driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Catherine Tipton Crites Robert Udell Crites ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cumberland MD 21502 531 Henderson Avenue Donna Abe daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/19/2008 Davis Memorial Cemetery MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Tunetal Service Licens e 108 Virginia Avenue: Cumberland, MD 21502 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediaty Cause (Final disease r condition resulting in death) **Physician** MONTH /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760年 Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pogistrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

oldtown Road, Cumberland, Md

		For State Registrar	State of	f Maryland / De <sub>l</sub> <i>C</i>	partment of I e <i>rtificate of</i>		_	giene Reg. No. 200	8 23880
Physic		1. Decedent's Name (First, Mid	ldle, Last) lizabeth (	lart or			2. Date of De Month July	ath Day Year	3. Time of Death
, /Medi , Exami		4a. Facility Name (If not institut			4b. City, Town, o	or Location of Death		4c. County of De	
	₹,	Sunrise Assi	sted Living	g of Columbi	a Colum			Howar	
Funeral Director		5. Social Security Number 579-56-3726	6. Sex 1 □ M 2 <b>½</b> F	7. Age (In yrs. last birthda 93 <sup>Yrs.</sup>	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	rthplace (State or Foreign Country) shington, DC
land ow		Usual Residence of Decedent  10a. State 10b. Coun	ity	10c. City, Town or	Location				10d. Inside City Limits
death with the Maryland rms 23a or 28a-f show rmst be notified at	ctor	MD Ho	ward	Columb	<b>i</b> a				1XYes 2 No
/ith the	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	•
eath v Is 23a must	eral	6311 Golden 1		dent Ever in U.S.	21044		nacify Vas or No	U.S.	
ite ite	by Fun	1 Name Status  1 Never Married 2 M: 3 Widowed 4 Divorce	Armed For arried 1 ☐ Yes If Yes Giv	2 🔀 No	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No		o Rican, etc.)	Black, Wh	ite, etc.
215-0036 tthin 72 hours aff ie. ie. "natural", or Medical Exami	Completed by	15. Deced (Specify only high	ent's Education hest grade completed)	16a. De	cedent's Usual Occup ve kind of work done b. DO NOT use retire	pation during most of wor	king	16b. Kind of Busines	s/Industry
2121 d within giene. er than , the Me	dmo	Elementary/Secondary (0-12	College (1	-4or 5+)	fessor	od)		College	
al Hyg	Be C	17. Father's Name (First, Middle				18. Mother's Nan	ne (First, Middle,	, Maiden Surname)	-
Maryland of 2 should be file lith and Mental Hy 27 is marked oth	P P	James M. Cart				<del></del>	Jackso		
Mar d 2 sh th and th and traum		19a. Informant's Name/Relatio  Edward R. Car						er, City or Town, State,	, Zip Code)
of Heal		20a. Method of Disposition		20b. Place of Dis	Golden Heposition (Name of rematory or other pla	i	Date MD	20c. Location - City of	or Town, State
Baltimore, bermit. Pages 1 a Department of Hee mportant: If Item any Injury or othe		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		State	Memorial	Cem July	12, 20	08 Suitlar	nd, MD
Balt permit. Depart Import any Inj		21. Signature of Funeral Service	ce Licensee					ineral Serv	
		23a. Part1. Enter the disease,	or complications that ca					ashington,	Approximate Interval Between
Physician		shock, or heart failure. L Immediate Cause (Final	ist only one cause on e	ach line. eimer's Demen				,	Onset and Death
/Medical	ı	disease or condition resulting in death)	u,	or as a consequence of):	ntla				5 Years
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uted	Examiner	Cause (Disease or injury that initiated events	- Due to (	or as a consequence or).					
O, e exect an and rrial-tra	Еха	resulting in death) Last	c Due to (	or as a consequence of):					
68760, Vificate be executed ficate be executed physician and streets the burial-transit	dical		d						
		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come pf pregnancy				23d. Date of d	elivery
death certif death certif de attending ed for use as	siciar	in the past 12 months?		ant at time of death	3 □Ectopic pregnand 5 □ Other <i>(sp</i> ec <i>ify)</i> _	у		Month	Day Year
P.O nat the d by the etache	Phys	9 ☐ Unknown  Part II. Other significant cond				usa is Dad I	ogo Did i	obacco use contribute	An Abra 2000 of Jank 0
Records, P.O. By he law requires that the death e has been signed by the atte age 2 should be detached for	Completed by Physician/M	Essential H	-	_	dilidenying cause gr	ven in Fait i.			Probably 4 Unknown
aw req	lete						24a. Was	an 24b. Were	autopsy findings available
_ r # 2	Somp						autoj perfo 1∐ Yes	ormed?   death?	o completion of cause of ? es 2 □ No
or Vital Physician: Titis certificate ral director, pa	Be	25. Was case referred to medie examiner?	Hospital:		l Out		ath (Check only o	one)	Aggigted
Phy rathis	<u>۲</u>	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date o	npatient 2 ER/Outpat of Injury 28b. Time	ient 2 DOA		T	dence 6 AOther (Sp	Assisted Living
Vision ( Attending I r death. ector: After by the funer	ation	1 X Natural 5 ☐ Pend 2 ☐ Accident inves	ding (Mont stigation	h, Day Year) Injur		rk? ]Yes 2 ☐ No		, ,	
Division  or Attending after death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	eminad   28e. Place	of injury - At home, farm, ng, etc. (Specify)	street, factory, office		28f. Location (City or Tol	Street and Number or i wn, State)	Rural Route Number,
Division  To the Hospital or Attence within 24 hours after death  To the Funeral Director: completely filled in by the items.				best of my knowledge, deasis of examination and/or					
thin 24	Medical	one) 29b. Signature and title of certi	and manr	ner stated.	29c. Licens			29d. Date signed (Mo	
		<b>&gt;</b>	M.	M.D.	D565			July 8, 20	
10		30. Name and address of person			e, Print)				700
		Harry Li, M.D	. 8600 Snow	den River P	wky, Suite	e 301 Col	umbia, 1	MD 21045	
Sta Regist	ate rar	31. Date filed (Month, Day, Yea	0 2008	egistrar's Signature	Carles				

			For State Registrar	State of	Maryla	nd / Depa	artment e rtificate	of Heal	lth and M ath	ental Hyg	giene Reg. No. 200	8	23881
	Physicia	an	1. Decedent's Name (First, Middle, Last Della, Chase							2. Date of Dea			3. Time of Death 4:30 P M
	/Medic Examin		4a. Facility Name (If not institution, give	street and num	nber)		4b. City, To	wn, or Loca	ation of Death		4c. County of		
t	Examin	er	Shady Grove Nur			ab			ville			TGOM	IERY
	Funeral Director		5. Social Security Number 6. Se			s. last birthday)	If Under 1 Months [		Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day Oct. 2	3,1917	Birthplac Country Mar	ce (State or Foreign y) yland
	p		Usual Residence of Decedent										
	arytar show d at	ř	10a. State 10b. County MD Montgo	moru	100.0	Cox	manto	V.712				100	<ul><li>Inside City Limits</li><li>1 ★Yes 2 No</li></ul>
	the M 28a-f otifie	Director	10e. Street and Number	лиету		Gei	10f. Zip C				10g. Citizen of Wh	at Country	
	with with the r	ă	21500 Ridge F	5so			101. Zip 0	208	176		U.S		, .
	ms 23	Funeral	11. Marital Status	12. Was Dece		U.S. 13.	Was Deceder			ecity Yes or No- Rican, etc.)		American	
36	be filed within 72 hours after death with the Maryland Ital Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	Armed For 1 ☐ Yes If Yes, Giv Year or Da	2 <b>X</b> No e		ir Yes, speciny 1 ☐ Yes 2 <b>y</b>		ecify:	rican, etc.)	Specify:	White, etc Bla	_
5-0036	'2 hou natura ical E	ted	15. Decedent's Edu (Specify only highest grad	ucation		16a. Dece	dent's Usual (	Occupation	a most of work	ina	16b. Kind of Busi	ness/Indu	stry
7	within 72 ene. <b>than "n</b> a' h <b>e Medic</b>	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.			g most of worki	ng			
7	filed wi Hygier other th	S	7th  17. Father's Name (First, Middle, Last)				Domes		Mothor's Name	/Einst Middle	Home  Maiden Surname)		
yland	Mental H arked otl atic ever	Be	James Hawkins	3				10.		na Wim:			
		ြ	19a. Informant's Name/Relationship (7)			19b. Maili	ng Address (S	Street and I			er, City or Town, Si	tate, Zip C	code)
<u> </u>	nd 2		Donna L. Tunne	11 (P	er Re	p) 215	00 Ri	.dge	Road,	Germa	ntown,	MD 2	20876
je Je	0 O L		20a. Method of Disposition	Damanal frame (	20b	Place of Dispo	osition (Name matory or oth	of er place)		Date	20c. Location - C	ity or Tow	n, State
Ĕ	Pages ment of ant: if it ury or o		1 M Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,		state	ohn We	sley	Cem		1/08	Clarks		
Baltimore,	permit. Page Department of Important; if any injury or once.		21. Signature of Funeral Service Licens	Mis	wde	11 A. 2	2. Name and . 246 N .	Address of Was	Facility SNO Shingto	OWDEN :	FUNERAL Rockvil	HOM le,M	ME, P.A. MD 20850
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	dications that can ear	aused the de	ath. Do not en	ter the mode	of dying, su	uch as cardiac	or respiratory and	rest,	1	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition	a (are	dom	lmone	ny a	1700	it			(	Onset and Death
	/Medical Examiner		resulting in death)	Due to (	or as conse	equence of):		140	_				
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	con	ge sty	re he	rant	tai	Ture				
Ď,	exection and and rial-tra		resulting in death) Last	Due to (	or as a conse	equence of):	-	-1					
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0	ertific ding p	Mec	IF FEMALE:	23c. If yes, out	come of prec	manov	1						
POX	death certific e attending p d for use as	cian,	in the past 12 months?	1 ☐Live b	irth 2 □ Fe ant at time o	etal death 3	☐Ectopic prec☐Other (spec				23d. Date Mont		/ Day Year
j.	the d	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□Unkno		r doddii - OL		""					
ν, T	The law requires that the de ite has been signed by the bage 2 should be detached	by Pr	Part II. Other significant conditions co	entributing to de	eath but not re	esulting in the u	nderlying cau	se given in	Part I.	23e. Did to	bacco use contrib	ute to the	cause of death?
ğ	equire en sig ould b	ed b								1 🗆 Y	res 2□No 3	Probal	bly 4 🖾 binknown
Hecord	law re as be	Completed								24a. Was a	sy pri		sy findings available pletion of cause of
	60 77	Com									rmed? / de	ath?	!□ No
VITAI	Physician: this certificatal director,	Be	25. Was case referred to medical examiner?	Hospital:				Other:		(Check only o			
0	≥ ্ছ চ	<u>۲</u>	1 Yes 2 No 27, Manner of Death	28a. Date o	•	ER/Outpatie		4			dence 6 Other		
-	tending Ph eath. tor: After th the funeral	tion	1 Natural 5 Pending 2 Accident investigation		h, Day Year)		M	lnjury at Work? 1 ☐ Yes		200. 2000201	ion injury coounion	u .	
UNISION	Attending r death. ector: Afte by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place	of injury - At	home, farm, st	reet, factory,	office		28f. Location (S City or Tow	Street and Number	or Rural	Route Number,
5	tal or s afte al Dir ed in	Certification:	4 I Torriede	Dullail	ng, etc. (Spe	uny)				City of Ton	ni, State)		
	To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun	Medical	29a. Certifier (Check only one) 1 Certifying Phy		asis of exami								
	To th withir To th comp	Me	29b. Signature and title of certifier					icense nur			29d. Date signed		ay, Year)
	7		· VV	7			P	067	1092		7/8/0	) &	
			30. Name and address of person who	ompleted cause				Cente	er Dr,	Rockvi	.lle, MI	20	850
100	Sta Registr		31. Date filed (Month, Day, Year)	108 32					· · · · · · · · · · · · · · · · · · ·				

State of Maryland / Department of Health and Mental	Hygiene
Certificate of Death	Reg. No.

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Reg. No.	4	U	U	0	4	J	(

			1 - State Registrar			Cei	rtificate of L	Death		Reg	g. No. 2	708	23882
	544	ħ	1. Decedent's Name (First, Middle	le, Last)						Date of Death		Year	3. Time of Death
	Physicia /Medic		Nellie	Hance	Cox					July 2,	2008		11:30 AM
	Examin		4a. Facility Name (If not institution				4b. City, Town, or				4c. Coun	ty of Death	
		644	Calvert Coun				Prince			Data of Dist		Calv	
	Funeral Director		5. Social Security Number 214-36-3472	6. Sex 7. 1 □ M 2 💢 F	Age (In yrs. la 102	ast birthday) Yrs.	If Under 1 Year Months Days		Min	Date of Birth (Month, Day, ept. 2	,1905	Coun	ace (State or Foreign ry) Land
	pui v		Usual Residence of Decedent  10a. State 10b. County	,	10c. City	. Town or Lo	ocation					16	Od. Inside City Limits
	shor shor	2			1,	,	ce Freder	rick					1 □Yes 2 🛣No
	the N 28a-f	ect.	MD Ca	alvert		LITII	10f. Zip Code	ICK		10	g. Citizen of	f What Coun	try?
	with 3a or 1 be r	Funeral Director	85 Hospital	Road				20678				U.S.	Α.
	ns 2%	Jera	11. Marital Status	12. Was Decede	ent Ever in U.S	3. 13.	Was Decedent of Hi If Yes, specify Cuba		n? (Specif	y Yes or No-		ace - America	
٥	after or ite		1 ☐ Never Married 2 ☐ Mar	rried Armed Force 1 Yes 2 If Yes, Give	₩No		il Yes, specify Cuba 1 □ Yes 2 💢 No	Specify:	ruello nic	an, etc.)	Spec	lack, White, o	ite
3-00-c	rai", C	d by	3 Widowed 4 ☐ Divorced	Year or Date	es:								
2	72 h "natu dical	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most o	of working	1	6b. Kind of	Business/Ind	lustry
7	within sne.	d L	Elementary/Secondary (0-12)	College (1-4	or 5+)	me.	homemak	•			0	wn hon	ne
<b>7</b>	Hygie ther ther	ပိ	17. Father's Name (First, Middle,	, Last)					s Name (F	First, Middle, M	faiden Surna	a <i>me)</i>	
/land	d be ental ked o	To Be			nce				Ly	dia	Bowe	en	
<u></u>	shoul nd M mar	-	19a. Informant's Name/Relations			19b. Maili	ng Address (Street	and Number	or Rural F	Route Number,	City or Tow	n, State, Zip	Code)
2	and 2 alth a 27 is		Donald W. Cox	k, son		6550	Southern	Mary1	Land	Blvd.,	Sunde	rland,	MD 20689
ore.	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 DRomoval from St	Ct Ct	emetery, cre	osition (Name of matory or other place		Date		20c. Location	n - City or To	wn, State
Ĕ	Pag ment ant: I		4 □ Donation 5 □ Other (		Mt.		ony Cemet				Owing		
Saltimo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ance.		21. Signature of Funeral Service	Licensee			2. Name and Addres			sch Fur			
_	Q □ = @ 0		William	- hora			325 Mt. H					ID 207	
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	it only one cause on each	th line.	i. Do not en	ter the mode of dyin	ng, such as ca	ardiac or r	1	, sst,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. /tc	w 9	_	vara (	17/	14	14.MIC	=7		
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o	death of attended for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	th 2 Feta	I death 3[	□Ectopic pregnancy □ Other (specify)	У				Date of delive Month	Day Year
j.	sician: The law requires that the death ocertificate has been signed by the attend rector, page 2 should be detached for us	Physician	1 ☐ Yes - 2 € No 9 ☐ Unknown	9□Unknow									
J.	that ned by deta		Part II. Other significant condit	tions contributing to dea	th but not resu	ulting in the u	inderlying cause giv	en in Part I.		23e. Did tob	acco use co	ontribute to tl	ne cause of death?
cords	requires that een signed b nould be deta	ed by							_	1 ☐ Ye	s 2₽¶o	3 □ Prob	ably 4 □Unknown
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r	The l	E								perforn		death?	2 No
VII	ian: ertifica etor, p	Be C	25. Was case referred to medic examiner?	al					of Death (	Check only one	-		
0	Physician: r this certific ral director,	To I	1 ☐ Yes 2 ☑ No	Hospital: 1 □ Inp			nt 3 DOA Oth	4 Nurs		e 5 ☐ Reside			y)
	Ing P		27. Manner of Death 1 ☐ Matural 5 ☐ Pendi	iriy i	Injury , <i>Day Year)</i>	28b. Time o Injury	Wor	ryat rk? ∣Yes 2∐No		d. Describe ho	w injury occ	curred	
<u>s</u>	ttend death. stor: /	icati	3 Suicide 6 Could		f injury - At ho	me farm st	reet, factory, office	res Z IN		f Location (St	reet and Nu	mber or Rura	al Route Number,
UIVISION	l or A after a Direct	Certification:	4 ☐ Homicide deteri	mined 200. Place of building	g, etc. (Specif	y)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier Certify (Check only one)	ring Physician: To the base at Examiner: On the base and manner	sis of examina	wledge, dea tion and/or i	th occurred at the tinner the tinner to the tinner the tinner to the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner the tinner t	me, date and opinion, death	l place, an	nd due to the ca	ause(s) and late and plac	manner as s ce, and due t	tated. o the cause(s)
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וום	15		30. Name and address of perso		of death (Item	123a) (Type	Print)	#310 F	Princ	e Fred	erick	, MD	20678
a,	Sta		31. Date filed (Month, Day, Yea.	32. Re	gietra Signa	ture	Sparke			.s rredi		,	
	Regist	rar	JU	L ( 4000)	MININ	es str	STORES	1					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** Mildred Mae Cox 5, 7:37 P M Ju1v /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/27/1915 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Mary Land 218-09-5732 92 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Calvert Chesapeake Beach 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3081 Cox Road 20732 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 X No Specify: ş Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 waitress restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Joseph Thomas Cox. Sr. Annie King 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Thomas Cox, Sr., nephew 3165 Twin Oaks Lane, Huntingtown, MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Harmony Cemetery 07/10/2008 Owings, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. nature of Funeral Service Lic March 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAC DYSRYTHMIA HOURS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. East of John, g Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 💹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X ER/Outpatient 3 □ DOA P 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural (Month, Day Year)

certificate be executed burial-transit Box 68760. physician the as aftending asn P.0. signed by the Division or Vital Records, page 2 s certificate Hospital or Attending Physician: 4 hours after death. After this funeral thin 24 hours arter control of the Funeral Director: After an Interest of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the fun

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

death v

72 hours after

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permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any Injury or other traun

**Physician** 

/Medical

Examiner

Saltimore, Maryland 21215-0036

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

JUL

D40370

29d. Date signed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Peter L. Wisniewski. M.D., 110 Hospital Rd., # 310, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registra Signature

State

DHMH 17 Rev 1/2001

2

Registrar

Medical

Please Type or Print in Black Indeliple Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Amend Item 20c per fh, g882 08/15/08/15/08/15 2008 23884 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month COLLYER 1:02 A M FAYE VANSANT July 2008 3 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **1934** 8 / 25 / <del>2008</del> Social Security Number 7. Age (In vrs. last birthday) 1 □ M 2 X F MD 220-32-7576 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No KENT ROCK HALL MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21746 SUNNYSIDE AVE. USA 21661 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2X No Specify WHITE Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) MARINE 12 BOOKKEEPER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MAYWOOD CROUCH SCOTT VANSANT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21746 SUNNYSIDE AVE. ROCK HALL, MD 21661 WILLIAM COLLYER/HUSBAND Rock Hall, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, 7/8/2008 WESLEY CHAPEL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
130 SPEER RD. CHESTERTOWN, MD 21620 Kuck Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one eause on each line. Immediate Cause (Final intaction acute my o cardial 20 minutes disease or condition resulting in death) Due to (or as a consequance of): multi-organ Due to (or as a consequence of): ung adeno Carcinoma Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 TYes 2 No 1 TYes 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury

/Medical Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. or Attending Physician:

attending physician and I for use as the burial-trar signed by the atter page 2 should be pe**e**n has certificate funeral director, After this

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

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Department of Health a Important: If item 27 is any Injury or other trainonce.

**Physician** 

Examiner

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu To the Hospital

2

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed 25. Was case referred to medical Be examiner? 1 Yes Certification: To 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

RES-000

State Registrar

, MEDICAL DOCTOR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

600 North Wolfe St. Baltimore, MD, 21287

July 3, 2008

32. Registr's Signature 07 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 28,2008 Bryon /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Rehab + Nursing Ctr.

| 6. Sex, | 7. Age (In yrs. labs birthday) Wicomica lisburu M Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days 1**⊠**M 2□F 126/1936 MD Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland ind Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at quoce. 1 Yes 2 No Pocomoke MD Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21851 Sandpit Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NA NIA NIA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NIA NIA ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NIA NIA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/11/08 SNOW HILL MD Deliverance Center 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 917 W. Isabella St. Salisbury, MD 21801 Bennie Smith Funeral Home 23a. Part. Ento the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examiner If any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b Was decedent pregnant 3 □Ectopic pregnancy Day signed by the atte Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed: certificate 2 1 NO or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 2 No 1 Yes 2 ER/Outpatient 3 DOA ၉ 1 ☐ Inpatient 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director; After thi
completely filled in by the funeral i 27. Manner of Death 1 Matural 28a. Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospitai within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner etated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

William H. Robins,

31. Date filed (Month, Day, Year)

JUL 1 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

miD.

Registrar's Signature

200

29c. License number

vic Ave,

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 8:25 a. Geneva Deloris Davis July 2008 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 21610 Creekside Drive **Allegany** Westernport Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours 1 □ M 2 🕱 F Yrs. Director 216-40-3259 73 July 12,1935 Swanton, MD Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location works Item 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumatic avant. The Medical Examinar must be notified at 1 ☐ Yes 2 X No Director MD **Allegany** Westernport 10e. Street and Number 10g. Citizen of What Country? death with 21610 Creekside Drive 21562 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in ont of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural", or Ital 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 ▼Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Tichinel Lo Juanita Warnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Dawson/Daughter 21610 Creek Side Drive Westernport, MD 21562 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State 20a. Method of Disposition 1 KBurial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Turner Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Smith Funeral Home 1 85 S. Main Street Keyser, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTAMO **Physician** neaus disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by should be 2. No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 this certificate has 1 ☐ Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Des ribe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No within 24 hours efter death, To the Funeral Diractor; Al 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and ordress of per second completed cause of death (Item 23a) (Type, Print) 7 Alida Podrumar, M.D. 904 Seton Drive Cumberland, MD 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature

Registrar DHMH 17 Rev 1/2001

State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July **Physician** 2008 05:42 AM Raymond Clarke Davidson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/17/1962 9. Birthplace (State or Foreign Country) California 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 563-72-3742 45 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Marvland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 United States 2446 Cedar Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 11 Never Married 2 ☐ Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: Completed by White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contractor Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Clarke Davidson Sharon Luella Granger ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon L. Davidson/Mother 1401 Diamond Street, Medford, Oregon 97501 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/08/2008 | Edgewater, Maryland Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 T Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27, Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After Injury 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 29a. Certifier 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month,)Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person cause of death (Item 23a) (Type, Print)

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year) 2008 JUL 08

ORIGINAL

			For State Registrar	State of Ma	ryland / [	Departi <i>Certif</i>	ment of H icate of I	lealth and N Death	Mental Hy	giene Reg. No.	2008	23888
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	/Medic		4a. Facility Name (If not institution, give			4b	. City, Town, or	Location of Death	June 2		County of Death	
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# For State

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State of Maryland / Department of Health and Mental Hygiene 2008

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Funeral Director

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Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

he law requires that the death certificate be executed e has been signed by the attending physician and age 2 should be detached for use as the burial-transit Records, P.O. Box 68760,

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၉	Martin Russell					E3	lsie T	hompson	n .				
	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (	Street and I	Number or F	lural Route Nu	mber, Cit	y or Town,	State, Zij	p Code)	
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Medical	(Check only 2 Medica one)	I Examiner: On the and ma	basis of examin inner stated.	nation and/or in	vestigation,	in my opinio	on, death oc	curred at the ti	me, date	and place,	and due	to the cause(s)	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 02, 2008 12:29 July Steave Ε. Freeman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery General Hospital Montgomery 01ney If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1**⊠** M 2□ F 79 April 03, 1929 Director 252-36-6243 Georgia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Modical Examinar must be recitified at 1 Types 2 □ No Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14402 Oakvale Street 20853 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
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Year or Dates: WWII 1 Never Married 2 Married 1 ∐Yes 2 TNo Specify à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Technical Sergeant (TSGT) U.S. Armed Forces 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vester Elisabeth O'Brian Lee Freeman Eleanora ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosa Freeman / Spouse 14402 Oakvale St. Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Department of Important: If it any injury or congress. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Crematory 7/10/2008 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart before. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Gastroutestinal **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown is been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation hours after death. uneral Director: A 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier axl

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene 23891 For State Registra AMEND#26perMD, 7-10=08, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician June 21, 2008 Naftali 12:30P M Futerman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1024 Crestfield Drive Rockville Montgomery 8. Date of Birth (Month, Day, May 28, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Sex 14 M 2□F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 126-42-0939 75 1933 Poland Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show if than "natural", or items 23a or 28a-f show the Wedical Examiner must be notified at FLPalm Beach Del Ray Beach 1 XYes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event. 13453 Cordoba Lake Way 33446 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Specify 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0wner Automotive Parts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pinchus Futerman Esther Straus ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - Wife Smadar (Sima) Futerman 13453 Cordoba Lake Way Del Ray Beach FL 33446 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 6/23/08 Judean Memorial Grdns Olney, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Edward Sage Funeral Direction Inc
1091 Rockville Pike Rockville MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer 2 Onsetand Death rs Immediate Cause (Final disease or condition resulting in death) Lung Cancer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician the dria the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been si r, page 2 should b 1 ☐ Yes 2 ANo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? 1 □ Yes 2 🛣 No certificate Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 🛮 Other Hospital: 1∐Yes 2∏No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural 2 Accident death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ည D62234 June 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manish Agrawal MD 9707 Medical Center Drive Suite 300 Rockville MD 20850 31. Date filed (Month, Day, Year) Registrar's Signature State JUL 10 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year  $J_{uly}^{Month}$  7, 2008 Physician 4:30 PM Stoffer Groninger /Medical a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 T F 1932 Mar 26, Ohio 76 283-28-6258 Director Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be notified at 1 ☐ Yes 2 🖾 No Director Montgomery Derwood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20855 18809 Muncaster Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White Specify 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) s 1 and 2 should be filed within: of Health and Mental Hygiene.
Item 27 is marked other than "I other traumatic event, I'm Max filed within Elementary/Secondary (0-12) College (1-4or 5+) Music/Education 4 Music Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Verda Turner Merle Stoffer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any Injury or other trai George E. Groninger/husband 18809 Muncaster Road Derwood, MD 20855 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 07/11/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Licensee Going Home Cremation Service P. O Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a.B-Cell Lymphoma year disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** months bMetastatic Disease to liver, lung, media-stinum.

Due to (or as a consequence of) multiple head and neck lymph nodes Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed c.Renal Failure 1 week and -trar burial-1 Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown ģ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has bage 2 s autopsy certificate 1 ☐ Yes 2 🗷 You 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation in 24 hours after we the Funeral Director: After Funeral Director: After fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundately filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental filled in by the fundamental f 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Rem D 0065485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Supanich, M.D. 1500 Forest Glen Rd. Silver Spring, MD 20910 32. Rasistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 1 1 2008

State of Maryland / Department of Health and Mental Hygieney 23893 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 13, **Physician** D2008 Galeazza John Μ. 2:33 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Charlotte Hall Veterans Home Charlotte Hall If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**™**M 2□F Months 579-36-7191 77 Director April 10,1931 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland St. Mary's Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with USA 29449 Charlotte Hall Road 20622 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: be filed within 72 hours a tal Hygiene... d other than "natural", o event, the Medical Exam <u>\$</u> Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Electrician Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be t is marked Giannantonio es 1 and 2 should b of Health and Menta item 27 is marked Nick Galeazza Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Wynn/ Guardian 29449 Charlotte Hall Rd., Charlotte Hall, MD 20622 permit. Pages 1 a
Department of Hei
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/15/2008 Charlotte Hall, MD Brinsfield-Echols 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P2Ac22 P.O. Box 128, Charlotte Hall, MD 20622 M00817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Pneumonia /Medical Due to (or as a consequence of): **Examiner** Dementia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached 1 Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown <u>Cerebro Vascular Accident</u> Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hypertension 1∐ Yes 2 🔯 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide x (sex) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of dertilier 29c. License number 29d. Date signed (Month, Day, Year) 1000 D67788 7.14.2008 MD OPLA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leena Rao Kodali, MDCharlotte Hall, MD 20622 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

23801.

Physic /Med Exami

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	Registrar			sen	uncate	e or L	Jeath			Reg.	No. 4	100	2303	r.b	
ian cal	haula Rae Hagen Goss  2. Date of Death July 07, 200											0 <sup>°</sup> 0°8	3. Time of Death 10:30A M	/1	
ner	4a. Facility Name (If not institution, give stree Frederick Memoria			$\operatorname{Fre}$	deri	ck	4c. County of Frede								
	5. Social Security Number 6. Sex 578-88-8618 1□ M		(In yrs. last birthday) Yrs.			if Under Hours	24 Hrs. Min.	8. Date of E (Month, L Nov .	24	1960	9. Birti Co Mar	hplace <i>(State or Foreig</i> untry) 'yland	ın		
	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Loc	ation							-	10d. Inside City Limits	e	
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ect	10e. Street and Number		rrec	ueı	ick	Codo				100	Citizen of	What Co	unto/2	_	
ă	613 Taney Avenue					217	<b>02</b>						tates		
era	11 Maritai Status 12. V	Vas Decedent	Ever in U.S.	13. W				igin? (Sp	ecify Yes or No Rican, etc.)			. Race - American Indian,			
Ξ	1 □ Never Married 2 □ Married 1	rmed Forces?  ☐Yes 2  ☐							Rican, etc.)			ck, White	e, etc.		
by	3 ☐ Widowed 4 🖾 Divorced	Yes, Give 'ear or Dates:		1	☐ Yes 2	X MVO	Specify:				Specif	y: <b>W</b> ]	hite		
etec	15. Decedent's Educatio (Specify only highest grade cor	n npleted)	16a. [	Decede Give k	ent's Usua kind of wor O NOT us	l Occup k done d	ation during mos	st of work	king	16	o. Kind of B	usiness/	Industry		
Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4or	0+)   .	-	emak		1)				Own	Но	mΘ		
ပို	17. Father's Name (First, Middle, Last)		11	Om	cmak		18. Moth	er's Nam	e (First, Midd	le, Mai				_	
To Be	Bruce Holte Hagen	L					San	dra	Gnan	t E	lagen				
	19a. Informant's Name/Relationship (Type. I		1	-	-	•			ral Route Nun				. ,		
	Kendra Hawk / Sis	ter						t.	Frede	ric	k, M	D 2	1701		
	20a. Method of Disposition 1 ☐ Burial 2 反 Cremation 3 ☐ Remo	val from State	20b. Place of the cemetery				<i>:e)</i>		Date <b>G</b>	200	c. Location	- City or	Town, State		
	4 □ Donation 5 □ Other (Specify)	vai ironi otato	Resthar				ry	uly 20	<u>08 '                                   </u>	Fr	eder	ick	, Marylar	ıd	
	21. Signature of Funeral Service Licensee			Re	Name and	d Addres aver	ss of Facili 1 Fur	ity 1era	.1 Ser	vic	es, S	Skko	ot Cody P.	Α.	
	23a, Part1. Enter the diseas	no that causes	the death. Do no	95	01 C	ato	ctin	Mtr	n. Hwy	. F	rede	rick	Approximate	01	
	shock, or heart failur. Only one cause on each line.										ļ	interval Between Onset and Death			
	disease or condition resulting in death)	Small-cell Lung Cancer  Due to (or as a consequence of):									months				
		Due to (or as	a consequence of	1).											
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as	Due to (or as a consequence of):												
ami	Cause (Disease or injury that initiated events c c														
n/Medical Examiner	Tooling in board, and	Due to (or as	a consequence of	ry:											
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iciai	in the past 12 months?	1□Pregnant a	2 ☐ Fetal death t time of death		Ectopic pre Other (spe		/					onth	Day Year		
hys	9 □ Unknown	∃□Unknown													
by F	Part il. Other significant conditions contribu	uting to death b	ut not resulting in	the un	derlying ca	ause give	en in Part	l.					the cause of death?		
ted	Renal Failure								1[	] Yes	2 □ No	3 □ Pr	obably 4 <b>∑</b> Unknow	n	
Completed by Physicia									24a. Wa	opsy	24b.	Were au	utopsy findings availabl completion of cause of	е	
									pe 1□ Yes	forme 2 <b>X</b>		death? 1 ☐ Yes	2□No		
Be	25. Was case referred to medical examiner?	ital:				Othe	or:		th (Check only					_	
<u>د</u>	I les 20 No	1 X Inpati					4 🗆 N	ursing Ho	ome 5 ☐ Re 28d. Describ				cify)		
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Cert	4 I Hornicide	bullaling, e	c. (Specify)						City or 1	own, a	state)				
Medical Certification:	(Check only 2 Medical Examiner:	of my knowledge, of examination and ated.	dge, death occurred at the time, date and place, and due n and/or investigation, in my opinion, death occurred at the						I due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)						
Me	29b. Signature and title of certifier				29c	. Licens	e number			29d	Date signe	ed (Mont	h, Day, Year)		
	· m				D	62	180			Ju	lly 7	, 2	800		
	30. Name and address of person who comple Fauzi Rizvi, M.D.					, F	rede	ric	k, MD	21	701				
ate rar	31. Date filed (Month, Day, Year)		ar's Signature												

			1 - For State Registrar	State o		d / Dep		Health an	nd Mental H	ygiene	•		395
	Physic	ian	1. Decedent's Name (First, Midd	,					2. Date of D Month	Da		3. Time of D	Death
	/Medi Examir		Mary Gladys Gre  4a. Facility Name (If not institution		ımber)		4b. City, Town, o	r Location of D	July 9		08 County of De	4:30	A <sup>IVI</sup>
1			Montgomery Gene				01ney				ntgome	ry	
	Funeral Director		5. Social Security Number 216-82-1986	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. 94	V	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, L	irth Day, Year)	9. B	irthplace (State or Country)	
			Usual Residence of Decedent						Sept.	9, 1	913   was	shington,	
	the Maryland 28a-f show	ţō				y, Town or Lo	cation					10d. Inside City	
	or 28a	Funeral Director	Maryland   Howard		Wood	bine	10f. Zip Code			10g. Cit	tizen of What C	Country?	
	s 23a	eral [	2938 Florence I				21797			USA			
G	after de or item	Fund	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	ried Armed Fo	2X No				? (Specify Yes or Nuerto Rican, etc.)	lo-	14. Race - Am Black, Wh		
5-0036		d by	3 X Widowed 4 ☐ Divorced	If Yes, Gi Year or D			1∐Yes 2∭MNo	Specify:			Specify: Wh	ite	
15-	C _ 60	Completed	(Specify only highe	nt's Education est grade completed)		16a. Dece (Give	dent's Usual Occu <sub>l</sub> kind of work done DO NOT use retire	oation during most of	working	16b. K	ind of Busines	s/Industry	
2121	d within /giene. er than "	Com	Elementary/Secondary (0-12)	College (	1-4or 5+)	homem				own	home		
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. item 27 Is marked other than other traumatic event, Inc. M.	Be	17. Father's Name (First, Middle,					18. Mother's	Name (First, Middi	e, Maiden	Surname)		
aryla	should nd Me mark matic	은	James Robert Di  19a. Informant's Name/Relations			19h Mailir	ng Address (Street	Emma W	. Tolbert r Rural Route Num	her City	or Town State	Zin Cada)	
Ĭ,	Health a tem 27 Is		Mary G. Gregg,						venue, 40				
ore	ges 1 If iten or oth	. 8	20a. Method of Disposition  1 X Burial 2 □ Cremation	3 □ Removal from	State 20b. P	lace of Dispo emetery, crer	sition (Name of natory or other pla	ce)	Date		ocation - City o		
Baltimore,	permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once.		Donation 5 ☐ Other (S	Specify)			e Cemeter		14/2008	Mou	nt Airy	, Maryla	ind
Ba	Depar Import any ir		De Sur la	1.51	9				Moleswort , Damascu				Home
			23a. Part 1. The the disease, o shock, or heart failure. List	complications that conly one cause on e	caused the death							Approximate Interval Between	een
8	Physician /Medical		Immediat Caus (Final disease or condition resulting in (1)	a	As	PIRA	TTON P	Nume	21/1			Onset and De	eath
and a	Examiner			Due to	(or as a consequ	ience of):	TWE	2145	222				
	ed sit	iner	Sequentially list conditions, if any learn in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	or as a constitution	witter off:	1,80,00	10 1 100	, , ,			way	
,	execut n and al-tran	Examiner	that initiated events resulting in death) Last	c	(or as a consequ	ence of):			·				
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ical		d									
39 x	certific ding pl	Physician/Med	IF FEMALE:	220 Hunn aut									
Box	death e atten d for us	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live I	tcome of pregnar birth 2□Fetal nant at time of de	death 3	Ectopic pregnanc Other (specify) _	у		:	23d. Date of de Month	,	ear
P.0	that the dended by the a	hys	9 Unknown	9 ☐ Unkn			., .,						
ds,	signed	ρχ	Part II. Other significant condition	ons contributing to de	eath but not resu	lting in the ur	nderlying cause giv	en in Part I.	TI .	tobacco u	/	to the cause of dea Probably 4 ☐ Un	
Records,	w requir s been s should	Completed				· · · · · · · · · · · · · · · · · · ·							
- Re	ate has	omo							— auto	psy ormed2/	prior to death?		use of
Vital	sician: Ih certificate rector, pag	Be	25. Was case referred to medical examiner?						☐ 1 ☐ Yes Death (Check only	2 No one)	1∐Ye	s 2□No	
of	this in dir	5.	1 ☐ Yes 2 ☑ No 27. Mann of Death	Hospital: 1 🗂	Inpatient 2 E	ER/Outpatien 28b. Time of		4 LI Nursin	g Home 5 ☐ Res			ecify)	
ion	death. ctor; After y the funer	atior	1 ✓ Natural 5 ☐ Pendin 2 ☐ Accident investig	q (Mon	th, Day, Year)	Injury	28c. Injur Worl M 1	Yes 2 □ No	28d. Describe	now injury	y occurred		
Division	or Atter fter de directo in by th	Certification:	3 ☐ Suicide 6 ☐ Could a determ	inca 28e. Place	of Injury - At hor ng, etc. (Specify	me, farm, stre	et, factory, office		28f. Location City or To	(Street and wn, State)	d Number or Fi	lural Route Numbe	er,
	ral led		29a. Certifier 1 Certifyin	g Physician: To the	hest of my know	vledge death	occurred at the ti	no data and al					
	ne no in 24 h he Fur pletely	Medical	(Check only 2 Medical one)	Examiner: On the ba	asis of examinati ner stated.	ion and/or inv	estigation, in my o	pinion, death o	ccurred at the time	, date and	place, and du	e to the cause(s)	
	within 2 To the complete	Ž	29b. Signature and title of certified	01			29c. Licens	number		29d. Dat	e signed (Mon	th, Day, Year)	
	10		30. Name and address of personal	lande	o of death (It.	22a) (T	1745	947		JUE	7 9,	2008	
	U		1.1 11	who completed caus	346 0	LAM) (Type, F	rinti)	INT. SI	UTE 20	0,0	serta,	m 208	132
79	Stat Registra	e .	31. Date filed (Month Day, Year)	2008 32	egistrar's Signati	19 do	well	, ,,,,	UTE 20				

			For State Registrar	State o	of Maryland			of Health of Death		lental Hy	giene Reg. No. (	2008	3 23896
- 10	8	В	1. Decedent's Name (First, Middle, Last)  2. Date of Death										3. Time of Death
	Physici /Medi	WITH TAM DAIDH CALLINGOT								Month JULY	Day	Year <b>2008</b>	2:42 A
	Examir		4a. Facility Name (If not institution	give street and nu	ımber)		4b. City, Tov	vn, or Location	of Death	Juli		County of Dea	
			16 BUDDY BLVI	).				SAPEAKI		Y		CECIL	
IĈ,	Funeral		5. Social Security Number	6. Sex 1 <b>X</b> M 2 □ F	7. Age (In yrs. la	as <i>t birthd</i> ay) Yrs.	If Under 1 Y Months D	ear If Under ays Hours		8. Date of Bi (Month, Da	rth ay, Yea <i>r)</i>	9. Bir	rthplace (State or Foreign ountry)
	Director		Usual Residence of Decedent			115.				OCT. 3	192	7	PA
	land ow at		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	Mary Fied a	호	MARYLAND CECI	т	Сп	ECADEA	KE CIT	w					1 ∐Yes 2 <b>X</b> No
	r 28a	Director	10e. Street and Number	.11	Un	ESAF EA	10f. Zip Co				10g. Citiz	en of What Co	ountry?
	h wit 23a o st be		16 BUDDY BLVD				21	915			IINTT	ED STA	TES
	ems deal	Funeral	11. Marital Status		edent Ever in U.S	S. 13. \	Vas Decedent	of Hispanic Or Cuban, Mexica	rigin? (Spe	ecify Yes or No		4. Race - Ame Black, Whi	erican Indian,
ထ္ထ	or it		1 Never Married 2 Marri	ed 1 TYYes	2 □ No		Yes 2.			r nodri, otor,		Specify: WH	
5-003	be flied within 72 hours after death with the Maryland Hygiene.  d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or D	Dates: 1944-4	45	•						
5	"nat	Completed	15. Decedent (Specify only highes	s Education t grade completed)		(Give	lent's Usual O kind of work d OO NOT use n	one durina mo	st of worki	ng	16b. Kin 	d of Business	/Industry
12	filed within 72 Hygiene. other than "na ent, the Medic		Elementary/Secondary (0-12)	College (	(1-4or 5+)		ARBER	stiredy			DAI	DOEDTN	a
0	filed Hygi other ent, tl		17. Father's Name (First, Middle, I	_ast)			ARDER	18. Moth	ner's Name	(First, Middle		<b>RBERIN(</b> Surname)	J.
<u>a</u>		To Be	WILLIAM GALL	UCCI					UNKN	OWN			
Maryland	s 1 and 2 should if Health and Mer item 27 is marke other traumatic	_	19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailin	g Address (St	reet and Numb			er, City or	Town, State,	Zip Code)
	1 and 2 Health a em 27 is		FLORENCE SWEETM	AN/COMPA	NTON	16 BU	DDY BL	VD., CH	ESAP	EAKE CI	ŢŢ,	MD 219	15
Φ	ges 1 a it of He if item or oth		20a. Method of Disposition 1 ☐ Buriat 2 X Cremation		20b. Pl	ace of Dispo-	sition (Name o	of i		ate		ation - City or	
Ĕ	Pages nent of ant; If it ury or o		4 □ Donation 5 □ Other (S <sub>k</sub>		HOM	E. P.A	D FUNE		07-1	5-2008	RTSTI	NG SIIN	MARYLAND
Sait	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service I	icensee /	1	22	. Name and A	ddress of Facil	lity R.T	<ul> <li>FOARI</li> </ul>	) FUN	ERAL HO	OME, P.A.
<u>n</u>	20 E P 9		front (	. / / /2	E/L	3	18 GEO	RGE ST.	, CH	ESAPEAR	Œ CI	TY, MD	21915
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that only one cause	aused the death ach line.	. Do not ente				r respiratory a	rrest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	а. (	0 0	N	(a	v Ce					onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consequ	ence of):							1/
	LAGIIIIICI	_	Sequentially list conditions,	b	(or as a consequ								
	ted Isit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ence or):									
	xecu al-trai	Examiner	that initiated events resulting in death) Last	c Due to	(or as a consequ	ence of):							
8/60	icate be execute physician and the burial-tran	dical E											
9	ifficate g phy as the	edic		u									
X R O	the death certificate be executed y the attending physician and iched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome pf pregnar		le				23	3d. Date of de	livery
n n	deat e atte	icia	in the past 12 months? 1□Yes 2□No	4☐Pregr	birth 2□Fetal nant at time of de		lEctopic pregn Other <i>(specit</i>					Month	Day Year
j.	at the by th tache	hys	9 ☐ Unknown	9□Unkn	nown								
– ທົ	The law requires that the de tte has been signed by the a rage 2 should be detached f	by F	Part II. Other significant conditio	ns contributing to d	leath but not resul	lting in the ur	derlying caus	e given in Part	I.	23e. Did t	tobacco us	e contribute to	o the cause of death?
ם ס	w requir been si should b						-			1 🗆	Yes 2	No 3□P	robably 4 🗆 Unknown
Hecords,	law r as be 2 sh	ompleted								24a. Was		24b. Were a	utopsy findings available completion of cause of
		Con									ormed? 2 2 No	death? 1 ☐ Yes	
Vital	Physician: r this certific ral director,	Be (	25. Was case referred to medical examiner?						e of Death	(Check only	one		
0	Physical this call dire	은	1 ☐ Yes 2 No			R/Outpatien				ne 5 Resi			ecify)
	ing l	jon:	27. Manner of Death  1 Natural 5 ☐ Pending		of Injury oth, Day Year)	28b. Time of Injury		Injury at Work?		28d. Describe	how injury	occurred	
S	Attending r death. ector: Affer by the funer	icat	2 Accident investigation 3 Suicide 6 Could not	at he	of injuny - At hor	mo farm etre		1 ☐ Yes 2 ☐		NO. 1	0		
=	al or Attendation after death	Certification:	4 ☐ Homicide determine	ned 200. Flace build	e of injury - At hor ling, etc. (Specify)	)	et, ractory, or	nce	4	City or To	Street and wn, State)	Number or H	ural Route Number,
	spital ours and neral		29a. Certifier	Physician: To the	e best of my know	vledge, death	occurred at t	he time, date a	ind place.	and due to the	cause(s) a	and manner a	hatete e
:	I of the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral dir	ledical	(Check only one) Medical E	xaminer: On the b	asis of examinati iner stated.	ion and/or inv	estigation, in	my opinion, de	ath occurr	ed at the time	date and	place, and du	e to the cause(s)
1	To th To th	Me	29b. Signature and title of certifier				29c. Lie	cense number			29d. Date	signed (Mon	th, Day, Year)
)			t all a	2		my	) D	0050	SHL	19		1/1//	DY S
			20) Name and address of person v	ho completed caus	se of death (Item	23a) (Type, I	Print)	1			1	1	FIKTA
1	+IVA		olaria Di	mone	son M	D (1	IW.	ttal	2	to Du	Vo	500	L MD 219
	Sta	-	31. Date filed (Month, Day, Year)	1 2008 <sup>32. F</sup>	Revistrar's Signati	ure	had s						
Ε.	Registr	ar	JOLI	- 2000	WILLIAM .	, , , , , , , , , , , , , , , , , , ,							

Registrar DHMH 17 Rev 1/2001 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008

1- For State Amend 26 per verbal G881 7/24/68rtFEate of Death

°2008 2389

			1 - State Amend 26 per Registrar	verbal G881	11241AB	rtificate of L	Death		Reg. No. 2 U U (	2389
-	Physic	ian	1. Decedent's Name (First, Middle, Last	)				2. Date of De Month	_	3. Time of Death
	/Medi		Dorothy (	Clark	Gott			07-	17-2008	1:53PM
1	Exami	ner	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Dea	th
			New Hope Assiste			Cumbe			Allegany	/
	Funeral Director		5. Social Security Number 6. Se 579-12-2792 Usual Residence of Decedent	7. Age (In)	yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da Aug 3	ly, rear)	thplace (State or Foreign ountry) VA
	yland low at		10a. State 10b. County		City, Town or Lo					10d. Inside City Limits
	h the Marylan r 28a-f show notified at	ģ	VA Loudo	un	Han	nilton				1 ∏Yes 2 ☐ No
	ith the or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	death with the Maryland ms 23a or 28a-f show r must be notified at		39058 Merak Ct.				20158		USA	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after der Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items any Injury or other traumatic event, the Medical Examiner monce.	by Funeral	11. Marital Status  1 □ Never Married 2□ Married  3 ☑ Widowed 4□ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 🍎 No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar I □ Yes 2□ <b>X</b> o	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	Specify:	
5-0	72 ho natu	eted	15. Decedent's Edu (Specify only highest grad	ication	16a. Deced	ient's Usual Occupa	ution	kipa	16b. Kind of Business	
2121	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done d OO NOT use retired)		Ving		
2	filed w Hygier ther th	ខ	12		Asso	<u>ciate Clerk</u>			Arlington C	County
Maryland	ould be fi Mental H arked otl	To Be	17. Father's Name (First, Middle, Last) <b>unknov</b> 'n				18. Mother's Nam  Mable	7	, Maiden Surname)	
Mar	d 2 sh th and :7 is m traum		19a. Informant's Name/Relationship (Ty  Deborah Money	<sup>/pe. Print)</sup> grd-daı	19b. Mailir 19 390	g Address <i>(Street a</i> <b>)58 Merak</b>			er, City or Town, State, . Nilton	Zip Code) VA 20158
	tem 2	-	20a. Method of Disposition		h. Place of Dispo	sition (Name of		Date	20c. Location - City or	
Baltimore,	Pages nent of nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation — 5 ☐ Other (Spacify)			natory or other place neral Home,		7/18/2008	Cresapto	,
alti	permit. Departm Importar any Inju	-	21. Signature of Funeral Service Licens		<u> </u>	. Name and Addres Scarpelli	i		Orcsapio	7/11 1/10
Ö	Depa Impo any In			1/1/1					nd. MD 21502	
I	Physician /Medical		23. Pp.11. Inter the disease, or composition, and the List only of Immediate Cause (Final disease or condition resulting in death)	a	5MB					Approximate Interval Between Onset and Death
	Examiner			Ductor as a cons	sequence ot):					
		ne.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of):					
	certificate be executed ding physician and se as the burial-transit	/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	o						
68760,	oe execian a	ŭ	resulting in death) Last.	Due to (or as a cons	sequence of):					
87	cate by	dica								
9 X	ding page as	/Me	IF FEMALE:	120 If you sustained of the						
P.O. Bo	The law requires that the death of the has been signed by the attenuage 2 should be detached for us	Physician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)	_		23d. Date of de Month	livery Day Year
	that ned by deta		Part II. Other significant conditions con	ntributing to death but not	resulting in the ur	derlying cause giver	n in Part I.	23e. Did to	obacco use contribute to	the cause of death?
ā	quires n sign uld be	d by						101	Yes 2 No 3 Pi	obabiy 4 🛮 Unknown
or Vital Records,	aw requir s been si 2 should t	Completed						24a. Was	an 24b. Were au	utopsy findings available
m.	: The lay	E O			_			autop perfo	rmed? death?	utopsy findings available completion of cause of
ita		Be C	25. Was case referred to medical	-			26. Place of Deat		2 ☐ No	2210
<u> </u>	nysic nis ce direc	To E	examiner? 1 Yes 2 No	lospitaf: 1 ☐ Inpatient 2	! ☐ ER/Outpatien	Othor	r.	ome <del>5⊡ Nesic</del>	Assisted	
D C	ding Pt .r After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injury Work?	at ?	28d. Describe h	now injury occurred	
sio	Attendideath.	catic	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	F-0		M 1 □ Y	es 2 □No			
Division		Certification:	4 Homicide determined	28e. Place of injury - A building, etc. (Spe	t home, farm, streecify)	et, factory, office		28f. Location (S City or Tow	Street and Number or Ru vn, State)	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	sician: To the best of my liner: On the basis of examend manner stated.	knowledge, death lination and/or inv	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the ored at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	901		29c. License	number		29d. Date signed (Mont	h, Day, Year)
			1500			Trace	UMALI		7/17	6
			30. Name and address of person who co	mpleted cause of death (I	tem 23a) (Type, F	Print)	1001		- /	
_			Shire Khanna			ational	High	Nay Lo	Wale Md	21502

DHMH 17 Rev 1/2001

Registrar

			1 - State	State of Ma	ırylan			nt of H te of L		Mental Hy			8	2389	18
			1. Decedent's Name (First, Middle, Last	<i>t)</i>			lilica	ie oi L	Jeani	2. Date of D				3. Time of Deat	h
	Physici /Medio		Annie .	House						Zizhi	Da	5 200	8	5:25 p	М
	Examir		4a. Facility Name (If not institution, give		-1	. \			Location of Dea	th 3		. County of D	eath		
			5. Social Security Number 6. Se		PIT	C()	_	er 1 Year	If Under 24 Hrs			Balt	1		
Н	Funeral Director			ox 7.Age ⊐M 2∭X F		Yrs.	Month		Hours Min	. (Month, D	ay, Year)		Country	e (State or Fore ) Alaban	5
	ס		Usual Residence of Decedent							Janua	ryz:	, 1918			
	arylar ehow	2	10a. State 10b. County			y, Town or Lo							10d	Inside City Lim 1 ☐ Yes 2 ☐	
	the M	ecto	New York Queen: 10e. Street and Number	S	Can	nbria		ghts ip Code			10= C	tizen of What			NU
	3a or	בוֹם	118-45 218th St	reet				411				A.	Country	*	
	ges 1 and 2 should be filed within 72 hours after death with the Maryland if of Health and Mental Hygiene. If Item 27 is marked other than "nature!", or Items 23a or 28a-f show or other treumatic event, the Modical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.	S. 13.			spanic Origin? (S	Specify Yes or N to Rican, etc.)		14. Race - A			
98	or ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ N If Yes, Give	0			ecily Cubai 2⊠ No	Specify:	to rican, etc.)		Black, W			
Maryland 21215-0036	hours ture!	ed by	3 Widowed 4 □ Divorced  15. Decedent's Edu	Year or Dates:							105 1	Specify: E			
5	n "na	Completed	(Specify only highest grad	de completed)		16a. Dece (Give life.	kind of w	rork done d use retired,	luring most of wa )	rking	100. 1	ind of Busine	ssymous	ary	
7	giene grene er the	Com	1.2	College (1-4or 5	-/	Cosme	etol	ogis	t		Cos	metol	.ogy		
g	be filed tral Hygie d other event, it	Be	17. Father's Name (First, Middle, Last)							me (First, Middle		Sumame)			
<u>\}</u>	2 should be and Mental is marked o	P	Mose Brower	in a China)		405 44-7				a Jarre					
Z Z	nd 2 sl lith an lith an 27 is r		19a. Informant's Name/Relationship (T) Ronald House/Gra							ural Route Numb t , Cambi				1171	201
ē,	f Hea Item		20a. Method of Disposition		20b. P	lace of Dispo	sition (N	ame of		Date		ocation - City			ו דנ
timore,	Page nent o ant: If ary or		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			-	-	•	1	7-23-0	Bro	ok l vr	l . Mo	w Vork	
Balt	permit. Pages 1 and 2 Department of Health s Important: if Item 27 is any Injury or other tre		21. Signature of Funeral Service Licens	0.0					e of Engilia		14-				
	20E # 9	1 1	Marzullo Funeral Chapel, P. 6009Harford Road, Baltimore, Maryland 21214												
			snock, or near failure. List only o	Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death											
	Physician /Medical		disease or condition resulting in death)	a Athero	$scl_{\epsilon}$	evotions	- C	igued	iovasc	slap	Dis	ease			
	Examiner			Due to (or as a	consequ	uence ot):									
		ner	if any, leading to immediate	b. Due to (or as a	consequ	uence of):									
	ecuted and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c											
60,	icate be executed physician and s the buriat-transit		rosuling in death) Last	Due to (or as a	consequ	uerice of):									
68760	ificate be executed g physician and as the burial-transit	edical		d											_
Box	eath certiff attending I for use as	M/	250. Was decedent pregnant	23c. If yes, outcome of	f pregna	ncy	]r=					23d. Date of	delivery		
	The law requires that the death certive has been signed by the attending age 2 should be detached for use a	Physician/M	in the past 12 months? 1  Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant at t 9 ☐ Unknown			Other (s	pregnancy specify)				Month	Da	y Year	
J.	res that the de signed by the a be detached f		9 ☐ Unknown  Part II. Other significant conditions co.		t not room	ulting is the			n in One)	22a Did	105			eause of death?	
Vital Hecords,	signe	d by	Part II. Outsi Significant Conditions Co.	intributing to death bu	1110111650	ntarg in the tr	iderlying	cause give	nun ranı.		Yes 2		Probabl	1.7	
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<u> </u>		BeC	25. Was case referred to medical				-		26. Place of De	1 ☐ Yes	one No	101	es 2L	□ No	_
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ב	ding Ph After th funeral	Ö	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury		28c. Injury Work		28d. Describe	how inju	ry occurred			
DIVISION	death death ctor: , the f	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	ny - At ho	me farm etr	M laste		es 2 No	28f. Location	Stront ar	od Number or	Pural D	auto Alumbos	
≧	after after Dire	Certification;	4  Homicide determined	building, etc.	(Specify	)	BBI, IACIO	ry, onice		City or To			nuiai n	oute ruilloer,	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifice completely filled in by the funeral director.		29a. Certifier  (Check only 2 Medical Exami	sician: To the best o	my knov	wledge, death	occurre	d at the time	e, date and place	e, and due to the	cause(s	and manner	as state	od.	
	the H nin 24 the F nplete	ledical		iner: On the basis of and manner stat	ed.	ion and/or inv				urred at the time,					
	C A C ON	Σ	29b. Signature and title of certifier	Mos	se.	00	25	C. License	number 55640		29d. Da	te signed (Mi		y, Year)	
	2	}	20 Nome of addition		0.4h //:	00-1 7	D-i	1100		7	نور	12 13	, .	3	
-			30. Name and address of person who co	Rd R	atri (item	11.	Print)	n	MD &	11133.					
9	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	's Signat	ure	40 -		,						
	Registra	ar	JUL Z 4 Z008	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1	1945									

State of Maryland / Department of Health and Mental Hygiene 23899 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Shirley June Halen 1426 July 15 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21585 Columbia Street Lexington Park St. Mary's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 XF 79 08/17/1928 Director Pennsylvania 172-20-1322 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location r 28a-f show 10a, State 1 ☐ Yes 2/XNo Directo Maryland St. Mary's Lexington Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a or Evartings must be 21585 Columbia Street 20653 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: White 3 ☑ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental I ပ Milton Beadling Helen Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21585 Columbia Street Lexington Park, Maryland 20653 Michael Krier / Son-In-Law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of I Important: If ite any Injury or of 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) B<del>rin</del>sfield-Echols Cre 07/17/2008 Charlotte Hall, MD. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons MOI2<del>06</del> 22955 Hollywood Road Leonardtown, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5+6 Physician 40 resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the 23e. Did tobacco use contribute to the gause of death? Division of Vital Records, Completed by 3 Probably 4 Unknown 1 Tes 2 No 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 s autopsy performed; 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₹No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation • Hospital or At.

• hours after death.

• I Director: A\*

hy the 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 34198 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20636 24035 Three Notch Road, Hollywood, MD David M. Federle, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 23900 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Christina Month 07 Antonietta Day Year Hilbert 09:24 am /Medical 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death St Mary's Hospital Leonardtown St. Mary's 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 31, Birthplace (State or Foreign Country) Year 1 □ M 2 🕅 F Months Days Hours Min. 219-62-3145 Director 77 Dec. Ϊ930 Italy Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

Item 27 is marked other than "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventine is not be recitived at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland | Saint Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27090 Elmer Ct. 20659 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Never Married 2 X Married þ 1 ☐ Yes 2 🔯 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress 12 Retail 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Angelo Bassi 2 Maria Asunta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James H. Hilbert ( Husband ) 27090 Elmer Ct., Mechanicsville, Maryland 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 ☑Other (Specify)Entombment Evergreen Memorial 07-19-2008 | Great Mills, Maryland 21. Signature of Funeral Service License ( Direct 22. Name and Address of Facility Brinsfield-Echols Funeral Home Cluand Danielle Ward M01403 30195 Three Notch Road, Charlotte Hall, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Va /Medical Due to (or as a consequence of) Examiner VOK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Exami signed by the attending physician and defacthed for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 MNo 23d Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð should I 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy performed? Yes 2 No certificate 1 □ Yes 1 Yes 2 10 : After this certification of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of the thick of t Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending (Month, Day, Year) after death

Director: / 2 Accident investigation 1 ☐ Yes 2 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours aft e Funeral Di eletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) -2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manjo Panwala D55027, 37767 Market Drive, Charlotte Hall, Maryland 20622 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 1 4 2008

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 በ Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Kenneth Jerald Harrison Julv  $\cap$ 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine 2520 Flagmarsh Road Carroll

9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 72 219-34-2663 **Director** 1936 Maryland Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 🛠 No Director Maryland Carroll Mt. Airy 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2520 Flagmarsh Road Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iter any injury or other traumatic event, the Medical Eventual ODE. Armed Polices: 15€Xes 2 □ No If Yes, Give Year or Dates: K & C&\ Year or Dates: 1 Never Married 2 Married 1 Tyes 2XXNo Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George W. Harrison 2 Margaret Della Hatfield 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha J. Harrison wife 2520 Flagmarsh Road Mt. Airy, MD \_21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Morgan Chapel Cemetery July 14, 2008 Woodbine, MD 21. Signature of Funeral Service Licenses Burrier-Queen Funeral Home & Crematory, 212 W. Old Liberty Road Winfield, MD and Compact States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and States and 22. Name and Address of Facility Approximate Interval Between Onset and Death im te Cause (Final disease or condition resulting in death) Cance **Physician** OVANCE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ed by the 1 ☐ Yes 2 ☐ No 9 I Inknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy 1 □Yes 2 1 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ope) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Watural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No s after death.

I Director: A

od in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records,

certificate

this c

After

death with the Maryland

Baltimore, Maryland 21215-0036

or items 23a or 28a-f show

To the Hospital o within 24 hours aff To the Funeral Di completely filled in A +10

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Johnson Dr. Frederick, mp 21702

31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 11 2008

08-05151 David Hall Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 23902 1- For State Certificate of Death Reg. No Registra 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Medical Examiner 0130 hrs David Anthony Hall July 5, 2008 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY g. Birthplace (State or Director 214-88-1785 Months Davs Hours Country) 1 X M 2 F 32 JAN.08,1976 MARYLAND Usual Residence of Deceden any 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 X No MARYLAND ANNE ARUNDEL with the Maryland ARNOLD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 930 DEFP CREEK AVE. 21012 UNITED STATES Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes hours after If Yes. Give Yee Widowed Yes 2 X No specify: 4 Divorced Specify: WHITE 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 I nent of Health and Mental Hygiene, College (1-4 or 5+) d other than " MD 21215-0036 12 ASSEMBLER 0 MACHINERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked Be UNKNOWN PEGGY CORCORAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tant: If item 27 is 1 or other traumatic **PEGGY** KUEBERTH (MOTHER) 930 DEEP CREEK AVE. ARNOLD.MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Itimore, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State KALAS CREMATORY 07-07-2008 EDGEWATER, MD. Donation 5 Other Specify 21. Sign e of F 22. Name and Address of Facility GFORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037 Physician 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval ure. List only one cause on each line. /Medical Between Onset and Death a Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and fransit The law requires that the death certificate be executed Physician/Medica tending physician use as the burial UNPENDED AMENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) signed by the att 1 Yes 2 No 9 Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 V No 3 Probably 4 Completed Records. ficate has been si page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? certificate ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death, director. 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Other 4 Hospital: 1 Inpatient this 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: 1 🗸 Yes 28a. Date of Injury Jul 5, 2008 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Natural 0051 hrs Operator of motorcycle involved in collision 5 Pending Yes 2 V No death. Funeral Director: stely filled in by the 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Monterey Ave and Ridgely Ave, Annapolis, MD determined (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal To the 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 5, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) istrar's Signature State 2008 JUL 08 Registrar

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006** 

State of Maryland / Department of Health and Mental Hygiene 23903 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>008</u> **Physician** FRANCIS MERRITT HICKMAN JULY 8, 06:59AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KENT CHESTERTOWN CHESTER RIVER MANOR 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 10/20/1917 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 X M 2 □ F 90 Director NY 075-12-0898 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits 28a-f show must be notified at **Funeral Director** 1 ☐ Yes 2 XNo MD KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a 10057 PERKINS HILL RD. USA or items 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. other traumatic event, the Mudical Examiner 1 Mayes 2 No If Yes, Give WWII Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify. Be Completed by Specify: WHITE 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, Ite IM. Elementary/Secondary (0-12) College (1-4or 5+) 12 FARMER AGRICULTURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JESSICA VIRGINIA TOOKER FRANCIS EDWARD HICKMAN ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10057 PERKINS HILL RD, CHESTERTOWN, MD 21620 JOE HICKMAN/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 \$\vec{\mathbb{M}}\$ Burial 2 □ Cremation 3 □ Removal from State 7/14/08 4 Donation 5 Dother (Specify) JOHN'S CEMETERY ROCK HALL, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 23a. vart1. Enter the disease, or complications that caused the double. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** ょ disease or condition resulting in death) /Medical Due to (or as a co END STAGE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the burial-trai Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown Be Completed 1 ☐ Yes 2 ☐ To Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Man of Death 28h. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 2 🗆 No 2 Accident investigation 1 TYes within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 12 Certifying Physician: To the dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State JUL 1 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JULY 6, HYMAN 20Ó8 9:06 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SUBURBAN HOSPITAL **BETHESDA** MONTGOMERY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Davs Hours 1 3 kM 2 □ F **Director** 03/19/1935 187-28**-**0687 PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Director MARYLAND MONTGOMERY SILVER SPRING 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2607 BAYVIEW LANE 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 1 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ▼No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PHYSICIST SCIENTIFIC RESEARCH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ LOUIS HYMAN GUSSIE ELLMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRIS HYMAN, WIFE 2607 BAYVIEW LANE, SILVER SPRING, MARYLAND 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State JUDEAN MEMORIAL GDNS 07/09/2008 OLNEY, MARY LAND 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part x Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sho k, or heart failure. List only one cause on each line. Extensive Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Stetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Day Year Month 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 □ No 1 Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ō 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Sion or Attending 1 ☐ Natural 5 Pending investigation 1 ☐ Yes 2 ☑ No 445 9/1 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5530 Wisconsin Achase Bathroom doctors office within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 10/04 the H 29b. Signature and title of certifier 29c. License number 0 20069 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #202 SO WEST ROCKVILLE BRAJENDRA FONONSTON DR NATH MISRA 31. Date filed (Month, Day, Year) . Registrar's Signature State 10 Registrar

DHMH 17 Rev 1/2001

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/Medi Exami		4a. Facility Name (If not institution	n. aive street and n			4b. City	Town, or	Location	of Death	oune 1	<del></del>	County of Dea	
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Funeral Director		5. Social Security Number none	6. Sex 1 X M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min. 4	8. Date of Bir (Month, Di 06/15/	2008	9. Bii C Ma	thplace (State or Foreigountry) aryland
Maryland f show	tor	Usual Residence of Decedent	vert	10c. Cit	y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 🎇 No
ith the or 28a oe notif	Director	10e. Street and Number				10f. Z	p Code	20657			10g. Citiz	en of What C	_
5-UU.30 72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	Funeral	12410 Hisp  11. Marital Status  1 X Never Married 2 Mar	Armed F	cedent Ever in U.	.S. 13.	Was Dece			gin? (Sp	pecify Yes or No Rican, etc.)	p- 1	4. Race - Am Black, Wh	erican Indian,
U36 urs aff al", or Exami	þ	3 ☐ Widowed 4 ☐ Divorce		2 X No Sive Dates:		1 ☐ Yes	2 <b>X</b> No	Specify:				Specify:	white
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once.	Completed		nt's Education est grade completed College	(1-4or 5+)	16a. Dece (Give life.	kind of w DO NOT	ork done o	durina mos	t of work	king	16b. Kir	nd of Business	s/Industry
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Maryland of 2 should be file th and Mental Hy to is marked oth traumatic event	To Be	Joseph Cha	rles He	sse, Sr	•			Sab	rina	Mari	ie :	Harris	
lary		19a. Informant's Name/Relation				•				ral Route Numl			Zip Code)
c, rv		Sabrina Marie	Hesse, Mo		124.			ia Kd		usby, N			r Town, State
Dallinore; bermit. Pages 1 ar Department of Hea mportant: If Item iny Injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		n State	cemetery, cre tropol	matory or	other plac					xandri	
it. Partmer		4 ☐ Donation 5 ☐ Other ( 21. Signature of Funeral Service		lue				ss of Facili					me, P.A.
any dany		1 William	R. 6	Tw-	_   8	3325	Mt. I	Harmo		ane, Ov			
at.		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that st only one cause or	caused the deat	h. Do not en	ter the mo	de of dyin	ng, such as	cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
BOX 68 / 60, eath certificate be executed xxa attending physician and for use as the burial-transit	lical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Ma Due to C. PRE	o (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the co	uence of):  ME U  uence of):  ME U	EL	CAG	SIN	4/	ASPHY	×11		y akasii.
Physician: The law requires that the death certificate be this certificate has been signed by the attending physicial director, page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   9   Unknown   9   Unknown   23c. If yes, outcome pf pregnancy   1   Live birth 2   Fetal death 3   Ectopic pregnancy   4   Pregnant at time of death 5   Other (specify)   9   Unknown   9   U								23d. Date of o			elivery Day Year
le law requires that the death has been signed by the atte	þ	Part II. Other significant condi	tions contributing to	death but not res	ulting in the u	ınderlying	cause giv	en in Part	l.			/	to the cause of death?
or Attending Physician: The law requires the face death.  Director: After this certificate has been signed in by the funeral director, page 2 should be considered.	Completed									per	s an opsy formed? 2 No	24b. Were a prior to death?	
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ending Feath.	ation:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work?  M 1 Yes 2 No							]No	28d. Describe			
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								28t. Location Cify or To	(Street an own, State	d Number or i	Rural Route Number,
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To the within To the comp	M	29b. Signature and title of certif	Demo			2		e number 4471	1			e signed (Mo	nth, Day, Year)
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Si Regis	ate rar	31. Date filed (Month, Day, Yea	UL 8 20	Registrar's gn	ature	* 4	Cart						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-04892 State of Maryland / Department of Health and Mental Hygiene Chicas H Santiago Certificate of Death 1- For State . Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day June 25, 2008 0849 hrs Santiago Chicas Hernandez **Medical Examiner** c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** Johns Hopkins Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year I ff Under 24Hrs. 7. Age (In yrs. last birthday 6. Sex 5. Social Security Number **Funeral** Months Days Hours Min. Country Honduras Director None Yrs 08/15/1969 1 X M 2 F Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 10a State ij 1 X Yes 2 No Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. Baltimore Md Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Hondruras 21231 1723 S. Lombard Street 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Mantal Status White, etc. Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 XMarried Yes 2 X No Specify: Hispanic 1 X Yes 2 No specify: Honduras Divorce Yes. Give Yea: 3 Widowed 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+ 21215-0036 Factory 9th Labor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Fidelina Hernandez Aguilar Isabel Chicas nolasco Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Baltimore, MD 1723 S Lombard St. Baltimore, Md. 21231 Luis Delcid/Bro-In-Law 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 07/20/08 Honduras General Cemetery tant: Donation 5 Other Specify 22. Name and Address of Facility 1501 21. Innature of Funeral S Mason Funeral Services Riverdale, Md. 20783 04 Cleveland Ave. Approximate Interval sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a, Part I. Enter the Physician Between Onset and failure. List only one cause on each line Medical a Multiple Blunt Force Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last g physician and s the burial - transit Physician/Medical AMENDED UNPENDED To the Hospital or Attending Physician: The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death signed by the attending be detached for use as t past 12 months Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 ✓ No 3 Probably 4 Unknown ģ Division of Vital Records, Completed 24b. Were autopsy findings available ficate has been si page 2 should b 24a Was an prior to completion of cause of autopsy performed? death? 2 No Yes 2 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical director, Be Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 Other DOA ER/Outpatient 3 this 1 Yes ۵ 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Subject assaulted Certification: Jun 23, 2008 0320 hrs 1 \_ Yes 2 V No Natural Pending within 24 hours after death.

To the Funeral Director:
completely filled in by the f 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State)
Patterson Park, Baltimore, MD (Specify) Outside 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 ica 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year)

(1 SIC

30. Name and address of person who completed cause of death (Item 23a) State

Registrar

29b. Signature and title of certifier

ron

Patricia Aronica-Pollak MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) 1 7 2008 OCME

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

June 27, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year 2:50P M 16,2008 PAULINE N/M/N HOWARD JULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4149 GATEWAY BLVD. WHITE CHARLES PLAINS 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Month, Day, Year 20 MAY 9, 1920 9. Birthplace (State or Foreign YORK, PA. 7. Age (In yrs. last birthday) **Funeral** Days Months 1 ☐ M 2 🔀 F 188-03-9840 88 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at MD. CHARLES WHITE PLAINS 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be r 4149 GATEWAY BLVD. 20695 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNO If Yes, Give 14. Race - American Indian, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or itel 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. Specify: WHITE Completed by 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EDWARD BECK LOTTIE KLINE ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERNARD HOWARD, SR.-SPOUSE 4149 GATEWAY BLVD. WHITE PLAINS, MD. 20695 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot ST.JOSEPH S CEMETERY 7-21-08 POMFRET, MD. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MD. 20646 21. Signature of Funeral Service Licensee M00479 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one care an each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 9 ☐ Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🌣 🔁 nknown 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy perform death? 1 ☐ Yes 2 ☐ No or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner' 1 Yes 2 No Hospital: Other: 4 Nursing Home Statesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. MATHUR Knistan 29b. Signature and title of certifie DR. 29c. License number 29d. Date signed (Month, Day, Year) 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 03

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 2 4 2008

32. Registrar's Signature

08-05345

Thomas Michael Inman

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 23908

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State of Maryland / Department of Health and Mental Hygiene 23909 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 14:42 PM Lillian Katherine Jackson 2008 July 6, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Hospital Elkton Cecil 8. Date of Birth (Month, Day, Year) 09/07/1930 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Min. Months Days Hours 1 □ M 2 🗙 F 154-50-8280 Director New York Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a, State 10b. County MD Cecil Elkton 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or Examiner must be 217 D Road 11 21921 USA Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? or items 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: à 3 ☐ Widowed 4 🔀 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise Flynn Joseph Schuck ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wendy Steele / Granddaughter 718 W. Glenwood Avenue, Smyrna, DE or other 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition United Crematory or other pla 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 07/10/2008 Newark, DE 4 □ Donation 5 □ Other (Specify) Services 21. Signature of Funeral Service Licensee 22 Strano & Feeley Family Funeral Home 635 Churchmans Road, Newark, DE 19702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** one /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury or as a nonsequence of): Examine death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9☐Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by pe 1 Yes 2 🗆 No 3 Probably 4 ☐Unknown peen 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? has page certificate 2 □ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending Natural 5 ☐ Pending investigation 1 🗌 Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) re and title of certifier 29b. Signa 2 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 223001 31. Date filed (Month, Day, State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 11:10 P <sup>™</sup> Virginia Ruth James 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 115 Austin Circle Berlin Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 € F 71 213-34-4811 12/26/1936 Director ΚY Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must hand the market once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director MD Worcester Pocomoke 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21851 714 10th St. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □ Yes 2 □**X**No Specify: þ white 3√Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Curtis R. Sexton Eleanor Price ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donna Winters / daughter 7084 Jackson Dr., Seven Valleys, PA 17360 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Cape Henlopen Crem. 7/11/2008 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral So 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Part1. Enter the diseas shock, or heart failure plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest y one cause on each line. Approximate Interval Between Onset and Death RCINDA Immediate Cause (Final LUNG Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence off Physician/Medical Examiner rany, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2☐ No. 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s certificate 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Residence 26. Place of Death (Check only one) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier )0002556 nd address of person who completed cause of death (Item 23a) (Type, Print) 30. Name BA 3 84h WO 100 omoke mo 2185 Monano 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 3,2008 2:30pm M Virginia Norman Jenkins /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Gaithersburg Montgomery Wilson Health Care Center 5. Social Security Number 579-74-9554 Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Ap(M4n1), D3y, 1e9/11 **Funeral** 6. Sex 9. Birthplace (State or Foreign V Prethnia 1 □ M 2 XF Days Hours Min. Director Usual Residence of Decedent the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show MD Montgomery Gaithersburg be notified 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 5 "natural", or items 23a 301 Russell Ave 20877 United States Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: à 3 ₩ Widowed 4 Divorced dother than "nature went, the Medical F Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Norman Jennie Longest ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Linda Norman/ Niece 5105 Newport Ave, Bethesda, MD 20816 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 N Removal from State 7-11-08 Oak Hill Cemetery Washington DC 4 Donation 5 ☐ Other (Specify) 21. Signatur / uneral Service Licensee 22. Name and Address of Facility oseph Gawler's Sons, INC 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) eau leine /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Exami burial-tra Due to (or as a consequence of): physician Physician/Medical the attending p If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig., page 2 should b 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death Check onl one 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 🗆 No 2 Accident

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: after death filled in by

To the Hospital within 24 hours a To the Funeral I

State Registrar

Medical

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifie

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2008

ddress of person who completed cause of death (Item 23a) (Type, Print) Melnich Ohn

10

6 ☐ Could not be

determined

31. Date filed (Month, Day, Year) 2008

Registrar's Signature

JUL

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician  ${\bf A}^{\,\,{\mathbb M}}$ Robert Douglas Jackson 4:25 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12926 Parran Drive Calvert Lusby If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Months 1 M 2 F 050-24-1659 78 New York 11/09/1929 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County MD Examiner must be notified Calvert Lusby 1 ☐ Yes 2 X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12926 Parran Drive 20657 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Armed Follows: 1 X Yes 2 □ No If Yes, Give 1947 Year or Dates: 1950 1 ☐ Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: 2 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager of Operations Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Jackson Anasthia Niemeyer ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12926 Parran Drive, Lusby, Maryland 20657 Eileen L. Jackson (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD. Veterans Cemetery 7/14/08 Cheltenham, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licenses any P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) vanced /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed Due to (or as a consequence of): attending physician Physician/Medical nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has 1□ Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No hours after death. Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Princ Frederick MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dew lat 1 meth 31. Date filed (Month, Day, Year) State JUL Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1 - State Registrar	State of Mar	ylarid		tificate			ental Hy	giene Reg. No. $20$	80	23913
	Physici	an	1. Decedent's Name (First, Middle, Last,							2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medi		William Joseph  4a. Facility Name (If not institution, give		r.		4b. City, Tov		n of Dooth	July		308	300 AM
j	Examir	ner	21001 Twin Spring	•				n, or Localic Newsvi			4c. County	shing	rton
out to	Funeral				(In yrs. last	t birthday)	If Under 1 Y	ear If Unc	ler 24 Hrs.	8. Date of Birt	h		ace (State or Foreign try)
	Director		140-20-0500	]M 2□F 8	1	Yrs.	Months Da	ays Hour	s Min.	(Month, Day	1927	Penn:	sylvania
	and w		Usual Residence of Decedent  10a. State 10b. County	1	10c. City, T	own or Lo	cation					10	Od. Inside City Limits
	/arylarylarylarylarylarylarylarylarylaryl	ō	Md. Washin		roo. Oity, r		sville						Marinside City Limits  YaYes 2 □ No
	the P	Director	10e. Street and Number	3			10f. Zip Coo	de			10g. Citizen of V	What Count	
	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show unatic event, the Medical Examiner must be notified at	a Di	21001 Twin Spri	ngs Dr.			,	21721			U . S		
	ems (	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. \	Vas Decedent	of Hispanic	Origin? (Spe	cify Yes or No- Rican, etc.)	14. Rac	e - America	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1/☐ Yes 2 ☐ No If Yes, Give	41-46		I□Yes 2			,,	Specify		
5-0036	hour tural	ed b	15. Decedent's Edu	Year or Dates:			lent's Usual O	cupation			16b. Kind of Bu	,,,,,	
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Maryland	S 8 8		19a. Informant's Name/Relationship (Ty)  L. Lea Kersting (	oe. Print) W <b>ife)</b>							r, City or Town,		,
	1 and Health tem 27 other tr		20a. Method of Disposition	-	20b. Place	e of Dispos	sition (Name o	f		ate	11e,Md.		
Baltimore,	Pages nent of I int: If its iry or o		XXBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	St. cem	etery, cren Larks	natory or other Episco neteru	place) P <b>a</b> 1	July 2008	21,	Boons	•	· _
<b>≣</b>	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service License		CHULC	22	. Name and Ad	idress of Fa	cility	125	525 Br <b>a</b> d	buru	Ave.
ñ	any Der		Jaffer /ce	Davis M	01414	J.	L. Davi	s Fund	eral H		thsburg		
		J	23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the cause on each line.	e death. E	Do not ente	er the mode of	dying, such	as cardiac o	r respiratory ar	rest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a	consequen	ce of):							7 - 00
	27.7	Į.	Sequentially list conditions,	. — Due to (or as a c	onsequen	ce of).							
١.	uted i insit	min	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Classes (Joseph Lander) that initiated events	200 10 (0. 00 0.	or recognition	00 01/1							
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x o n	death cert e attending d for use a	sician/N	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf 1☐Live birth 2	☐ Fetal de	ath 3	Ectopic pregna					te of deliver	y Day Year
	the de y the a iched f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown	ne of death	n 5	Other (specify	/)			l livio	1101	Day real
1	w requires that the de been signed by the should be detached	/ Phys	Part II. Other significant conditions con	tributing to death but i	not resulting	g in the un	derlying cause	given in Pa	rt I.	23e. Did to	bacco use contr	ribute to the	e cause of death?
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Records,	law red as bee 2 shou	Completed								24a. Was a	ın 24b. V	Were autop	sy findings available
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N I Cal	ysician; The lavis certificate has director, page 2	Bec	25. Was case referred to medical examiner?					26. Pla	ace of Death	(Check only or		. <u>П 163</u> .	2 140
2	Physician; this certific ral director,	은	1 ☐ Yes 2 ☑ No	ospital: 1   Inpatient		<u>_</u>	3 □ DOA	Other: 4 🗆	Nursing Hom	ne 5 Aesid	ence 6 🗆 Oth	er (Specify	)
	0 0 0	ö	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	'ear) 281	b. Time of Injury	'	njury at Work?		8d. Describe h	ow injury occurr	ed	
UNISION	Attending r death. ector: After by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury	- At home	farm stre		I∏Yes 2	-	Of Location /C	treet and Numb	or or Puml	Pouts Number
2	after after I Dire d in b	Certification:	4 ☐ Homicide determined	building, etc. (	(Specify)	, idilli, otic	et, lactory, on	00	2	City or Tow	n, State)	er or nurar	noute Number,
	ospita hours unera y fille		29a. Certifier 1 Certifying Phys	ician: To the best of r	my knowled	dge, death	occurred at th	e time, date	and place, a	nd due to the o	ause(s) and ma	nner as sta	ated.
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral directal di	Medical	(Check only 2 ☐ Medical Examir one)	ner: On the basis of ex and manner state	kamination	and/or inv	estigation, in r	ny opinion, c	death occurre	ed at the time, o	late and place,	and due to	the cause(s)
	To T To I	Σ	29b. Signature and title of certifier	0 1				ense numbe			9d. Date signed		
			mulael	milan	ul	MO	0	416	67		7 ^	17.	06
	8		30. Name and address of person who co				Print)	1	/			H	stown M
	Sta	to	31. Date filed (Month, Day, Year)	MCCU / A			1110	med	(cel	(arr	MUJ 1	Way C.	strung M

State

Registrar

JUL 2 4 2008

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Helen M. Kelly July 2008 10:10a M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Northampton Manor Nursing Home Frederick Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 🖾 F Months Days Hours Director 579-36-5637 78 Feb. 13,1930 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 502 H Bradley Court 21703 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. à Specify: 3 ₩ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be finent of Health and Mental is marked o ည William Otley Helen Burns 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any Injury or other trau Clare Lawson / Daughter 503H Bradley Court, Frederick, Maryland 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State 7/9/2008 4 Donation 5 ☐ Other (Specify) Mary's Catholic Cemetery Knoxville, Maryland 21. Signature of 22. Name and Address of Facility Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disease, or complicating that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PROGRESSIVE **Physician** SUPRANUCLEAR MANY YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of). If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) by signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 □ No 2 No 1 ☐ Yes funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural ∴ s after dea. •• al Director; ↑ •in by t\* 2 Accident 1 ☐ Yes 2 🗆 No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely (Check only one) within 2 29b. Signature and title of certifie 1016675 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ) KINE MUCHIER J RUWSWICK egistrar's Signatu 31. Date filed (Month, Day, Year) State 2008 JUL 1 0 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 23915 1- State Amend Item 25 per me, 9882, 08/08/08/date of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JULY 2008 ROBERT **EDWARD** KEILHOLTZ 4 SR 12:59P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 🛣 M 2 🗆 F Months Hours Min. Director June 18, 214-28-0303 79 1929 Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examining must by notified at Director 1 ☐ Yes 2X No Maryland Frederick Rocky Ridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 14519 Old Frederick Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Evantiner rives any injury or other traumatic event, the Medical Evantiner rives any once. 21778 by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 ∐Yes 2 12 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carroll C. Keilholtz ဂ Dulcie Larue Burdette 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17320 Robert E. Keilholtz, Jr. Son 24 Steelman Marker Road Fairfield, Pennsylvania 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Ju1y 7 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 2008 Frederick, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 104 E. Main Street Thurmont, Maryland 21788 23a. Part 1. Enter the disclase, ir complications that caused a shock or heart failure. List only one cause on each line r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition Henmorhas /Medical Due to (or as a consequence of). Examiner Anticogoluctu hours if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) OERTIFICATION APPROVED BY MEDICAL and the burial-trai The law requires that the death certificate be exec Due to (or as a consequence of). P.O. Box 68760. physician Physician/Medical be detached for use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 Was ...
autopsy
performed?
ves 2 11 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Hospital: 1 XYes ZER Certification: To 1 Ampatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner - Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospina. Within 24 hours after death.
To the Funeral Director: After To the Funeral Director: After To the Funeral Director: After To the Funeral Director: After To the Funeral Director: After To the Funeral Director 1 -If atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) a MD D66166 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 W. Seventh Street Frederick, Maryland 21701 dusar 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Registrar 2008

DHMH 17 Rev 1/2001

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ex

08-05507 Walter A. Loy

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		1- For State Registrar	,	Certific	ate of De	eath		Re	g. No.	00 2391	
Physic		Decedent's Name (First, Middle,La	Name (First, Middle,Last)  2. Date of Death Month Day Year								
Medical Exam	iiner	Walter  4a. Facility Name (if not institution, gi	A. Loy,	Jr.	14b.C	ity, Town, or Loca	ation of Dooth	July 18, 20	4c. County of Deal	0635 hrs	
		27160 Oriole Road, Princ		853	- 1	incess Anne			Somerset	"	
Funera	1	Social Security Number 6. 5	Sex 7. Age (	In yrs. last bir	thday) If	Under 1 Year II	f Under 24Hrs	. 8. Date of Birt	h(MM/DD/YYYY) 9. Bi		
Directo	ī	183-22-8806	XM 2 F	77	Yrs. M	onths Days	Hours Min.	10-24	-1930 Fore	ign ountry) PA	
		Usual Residence of Decedent									
w any		10a. State 10b. County		c. City, Town	or Location					10d. Inside City Limits	
Maryland 28a-f show d at once,	ğ	MD Somers	et	Prin	cess A				<u> </u>	1 Yes 2 No	
Mary r 28a- ed at	Director	10e. Street and Number	- 4		10f	. Zip Code 21853	•	10	g. Citizen of What Co USA	untry?	
death with the Maryland or items 23a or 28a-f sho must be notified at once.	<u>e</u>	27160 Oriole Ro			140.141 5						
ath w	Funeral	11. Marital Status  1 Never Married 2 Marrie	12. Was Decedent Ev			cedent of Hispani pecify Cuban, Me			White, etc.	rican Indian, Black,	
her de	_	3 Widowed 4 Divorce	1 Yes 2 X d If Yes, Give Year	No	1 Yes	2 No · sp	ecify:		Specify: W	hite	
ours a atura xamir	d by	15. Decedent's Education (Specify	only highest grade compl	eted) 16a.		sual Occupation (			16b. Kind of Business	/Industry	
16 n 72 h nan "n ical E	lete	Elementary/Secondary (0-12)	College (1-4 or 5+		-	working life.DO		rea)	Poultr	.,	
21215-0036 Mental Hygiene. marked other than "matural", or items 23a or 28a-f she event, the Midical Examiner must be notified at once event, the Midical Examiner must be notified at once	Completed	17. Father's Name (First, Middle, Las			becui			(First Middle A	Maiden Surname)	y	
e filed tall Hy	Be C	· · · · · · · · · · · · · · · · · · ·	,				lna M.		naiden Sumame)		
212 buld b I Meni	2	Walter A. Loy, 19a. Informant's Name/Relationship (	Type, Print )	19	b. Mailing Add				ber, City or Town, Stat	e, Zip Code)	
MD Id 2 sho lith and Im 27 is		Carol Ann Bonitz	Loy/Wife	2	7160 Oz	riole Ro	ad, Pr	incess	Anne, MD 2		
s l an f Hea If iten		20a. Method of Disposition  1 Burlal 2 Cremation 3	Removal from State		of Disposition tory or other pl	(Name of cemete ace)	егу,	Date	20c. Location - City of	r Town, State	
Page Page nent o		4 Donation 5 Other Specific			bury C	rematory	7/2	1/2008	Salisbury	, Maryland	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27; is marked other than "natu		21. Signature of Funeral Service Lice	/ . /		22. Name Hinma	and Address of F an Funer	al Hom	e			
		23a. Part I. Enter the disease, or com	May Mo	0295	11673	Somers	et Ave	., Prince	ress Anne,	MD 21853 Approximate Interval	
Physician (Medical		failure. List only one cause on e	ach line							Between Onset and Death	
xamine	/	Immediate Cause (Final disease or condition resulting in death)	atheros	clerotic	Deali						
		Sequentially list conditions,	·								
	miner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequ	uerice of).							
-	1 G	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):							
760, icate be executed physician and the burial - transit	1		AMENDED #1 &	e note	ad. 23a	.27. nerN	ME. GRE	3 9/5/0	8 1"1"	-	
760, cate be exe physician a	//Medica					, 27 , peri					
8760, tificate be ng physic as the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome  1 Live birth		2 Fetal de	ath 3 E	Ectopic pregna	incy	23d. Date of delive Month	ry Day Year	
Box 68 e death certif the attending ed for use as	icia	past 12 months?  1 Yes 2 No 9 Unknow	4 Pregnant at tin		5 Other (						
that the death certifuled by the attending detached for use as	Physician	Part II. Other significant conditions	9 Unknown		- 1- 45		i- D-d I	220 Did to	bacco use contribute t	a the series of death?	
, P.O. ires that the signed by		rait ii. Other significant conditions	contributing to death b	ut not resultin	ig in the under	lying cause given	illi Parti.			obably 4 Unknown	
rds, require been sig	ompleted							24a. Was a	an 24b. Were a	autopsy findings available	
COF law r has b	du				<del></del>			autop perfor	sy prior to	completion of cause of	
tal Recordian: The law certificate has ector, page 2 sl	Co	OF Management and district				00 51(5	311 (01	1 ✔ Yes	2 No 1 🗸	Yes 2 No	
Vital Recysitian: The I	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 FR/O	utpatient 3	DOA Othe	Death (Check		Residence 6 V Oth	er: Scene	
n of Vit ding Physia After this funeral dire	-	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Year		Time of Injury	28c. Injury at	Traisin.		now injury occurred		
OD on ending ath.  or: A the further further further further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at the further at th	GIOLIX Natural -										
Division of Vital Records, tat or Attending Physician: The law requin as after death.  al Director: After this certificate has been sided in by the fineral director, page 2 should by	ifica	3 Suicide 6 Could no	28e Place of Injur	y - At home, fa	arm, street, fac	tory, office buildi	ing, etc.	28f. Location (S or Town, S		Rural Route Number, City	
Div spital or neral Dir filled in								or rown, s			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri.		(Check only	ian: To the best of my ker: On the basis of examin								
To ti within To ti	Medical	29b. Signature and title of certifier			29c. License nu			29d. Date signed (M			
		Da (. 10	11 00 0			O.C.M.E			July 19, 2008	J, 50,,100/	
		30. Name and address of person who	completed cause of dea	th (Item 23a)					,,		
		Pamela E. Southall, MD	Assistant Medica	,	er 111 Pe	enn Street, B	altimore, N	/ID 21201			
S	tate	31. Date filed (Month, Day Year) 2	2008 32. Registar's	Signature	& dan	els i					
Regis	strar	JUL & &	2000	, , r	14/100						

21093

TIMONIUM

LAZAR or Vital

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIO MAHMOOD, M.D. 2300 DULANEY VALLEY ROAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

			1 - For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of H rtificate of L	ealth and N Death	lental Hyg	iene eg. No. 2 0 (	08 23918		
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  Marian C. Lo					2. Date of Deat Month July 9	th Day	Year 7:20 P M		
	Examir		4a. Facility Name (If not institution, give s Golden Living Co	· ·		4b. City, Town, or Westmins	Location of Death	<u> </u>	4c. County o	of Death		
	Funeral Director			7. Age (In yrs. 93	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth DeC • 15	, <sup>Yea</sup> 1914	9. Birthplace (State or Foreign Wilkinsburg, Pa		
	Maryland a-f show ified at	tor	Usual Residence of Decedent  10a. State 10b. County  MD Carroll		y, Town or Lo					10d. Inside City Limits 1		
	h with the 33a or 28s st be not	Funeral Director	10e. Street and Number 505 High Acre Driv	e, Apt.#327		10f. Zip Code 21157			0g. Citizen of WI	hat Country?		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 Never Married 2 Married  * Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cuba I □ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc. White		
21215-0036	I within 72 ho piene. r than "natur the Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give life. L	dent's Usual Occupa kind of work done d DO NOT use retired, ance Couns	luring most of work )	ing	16b. Kind of Bus			
Maryland 2	buld be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Frederick R. Carry	th		]	18. Mother's Name Reba Ying	e (First, Middle, M	Maiden Surname	)		
	1 and 2 should Health and Men tem 27 is marke other traumatic	•	19a. Informant's Name/Relationship (Typ. Jane Woerner - Dau	· .		g Address (Street a						
altimore,	. Pages 1 Iment of Hi tant: If iter jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ACremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Cal	rroll C	sition (Name of natory or other place cremations	7/10	/2008	Hampst			
Ba	permit. Departr Importa any Inji		21. Signature of Funeral Service License		41	.2 Washing	gton Rd.,	Westmir	nster, M	ne & Chapel, P.A ID 21157		
	Physician and physician and street between the pural-transit street burlan-transit stree	dical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence to (or as a consequence)	uence of : uence of):	ate V	accus accus accus accus	dent De	Alase	Approximate Interval Between Onset and Death Codings  Codings		
.O. Box 68	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome pf pregna 1			23d. Date Mont	of delivery th Day Year				
Records, P	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions cont	ributing to death but not res	ulting in the un	derlying cause give	n in Part I.	23e. Did tob		oute to the cause of death? B ☐ Probably 4 ☐Unknown		
_	The law ate has b page 2 sh	e Completed	25. Was case referred to medical				00 Disease ( Disease)		prined? de	ere autopsy findings available ior to completion of cause of ath? □ Yes 2 □ No		
on or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	ertification: To B	26. Place of Death (Check only one)  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Aurusing Home 5 Residence 6 Other (Specify)  27. Manner of Death 1 Aurusing Home 5 Residence 6 Other (Specify)  28a. Date of Injury 28b. Time of Injury 4 Work? 2 No 1 Year 1 Yes 2 No 28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred									
	ne Hospita 124 hours Te Funeral	edical C	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the timestigation, in my op	e, date and place, inion, death occur	and due to the ca ed at the time, da	iuse(s) and mani ate and place, an	ner as stated. nd due to the cause(s)		
	To the comple	Me	29b. Signature and title of certifier	Adter M.D		29c. License			1 1	(Month, Day, Year)		
	Sta Registr		30. Name thy address of person who con the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	32. negotiais Signa	23a) (Type, F	Street	Mana	heste	M	1>2/102		

			1 - For State Registrar	of Maryland / Dep <i>Ce</i>	artment of Health and N	Mental Hygie	ne No. 2008	23919
Н	Physic	ian	1. Decedent's Name (First, Middle, Last)			Date of Death     Month	Day Year	3. Time of Death
-	/Medi Examir		QUANITA T  4a. Facility Name (If not institution, give street and		LES  4b. City, Town, or Location of Death	JULY 7	4c. County of Death	4:43 A M
	LAGIIII	iei	19415 Jerusalem Rd.		Poolsville		Montgomer	J
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ M 2 ☐ M	7. Age (In yrs. last birthday) 30 Yrs.	If Under 1 Year   If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye April 2, 1	ar) 9. Birthi	place (State or Foreign
	rland ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation		1	0d. Inside City Limits
	e Mary Ba-f sh	ctor	Maryland Montgomery	Pooles	sville			1 □ Yes 2X No
	th with the Marylan 23a or 28a-f show	Funeral Director	10e. Street and Number 19415 Jerusalem Road		10f. Zip Code 20837		Citizen of What Cour	
	death	inera		ecedent Ever in U.S. 13. Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ	can Indian,
9036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Exeminar must be redified at	d by Fu	1 X Never Married 2 Married 1 ☐ Ye	s 2∏No	1 ☐ Yes 2 🔯 No Specify:	Hican, etc.)	Black, White, Specify: B1	etc. .ack
15-(	er 2 30	Completed by	15. Decedent's Education (Specify only highest grade complete	(Give	dent's Usual Occupation hind of work done during most of work DO NOT use retired)	ring 16b	. Kind of Business/In	dustry
212	2 should be filed within and Mental Hygiene. is marked other than "sumatic event, Ihe Ma.	Comp	Elementary/Secondary (0-12) College 1 2	e (1-4or 5+)	labor	Ed	lucation C	enter
and	ould be file Mental Hy larked oth	Be	17. Father's Name (First, Middle, Last)  George W.	T 1		e (First, Middle, Maio	,	
r Š	hould nd Mei marke matic	은	George W.  19a. Informant's Name/Relationship (Type. Print)	-,200	Charles  ng Address (Street and Number or Rui	ne Y. Lo		
Ma	alth ar 27 is		Charlene Lyles / Moth		5 Jerusalem Rd./			
Baltimore, Maryland 21215-0036	Pages 1 and 2 should ent of Health and Mer nt: If item 27 is marke y or other traumatic		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	m State 20b. Place of Dispo cemetery, crei	osition (Name of matory or other place)	Date 20c	. Location - City or To	own, State
Baltii	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.		21. Signature of Funeral Service Licensee	22	n Mem.Garden 07/10 2. Name and Address of Facility Sta	auffer Fun	eral Home	
			23a. Part 1. Ent the disease, or complications the	t caused the death. Do not en	621 Opossumtown Protect the mode of dying, such as cardiac		rick, MD	21/02 Approximate Interval Between
4	Physician /Medical		shock, of neart failure. List only one cause of Immediate Juse (Final disease or condition resulting in death)	Ceubral	Palsy			Interval Between Onset and Death
Y	Examiner		Due	to (or as a consequence of):	isoide			
	ed sit	iner	Sequentially list conditions, if any lee-ting to him, ediatic cause. Enter Underlying Cause (Disease or injury that initiated events	to (ories a consequence of):				
΄,	execut in and ial-tran	Examiner		to (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	dical	d					
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delive	ery Day Year
Records, P.	luires that n signed b		Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I.		co use contribute to the	ne cause of death?
ecol	e law requir has been s je 2 should l	Completed by				24a. Was an	24b. Were auto	psy findings available
a R	<b>hysician:</b> The la his certificate ha I director, page 2					autopsy performed 1 ☐ Yes 2 █	death?	mpletion of cause of 2 No
Vital	sician certif rector	Be	25. Was case referred to medical examiner?  Hospital:		Other	h (Check only one)		_
ō	ding Phy: h. After this funeral di	بر آب	27. Manner of Death 28a. Da	☐ Inpatient 2 ☐ ER/Outpatier te of Injury 28b. Time of	1 3 DOA 4 Nursing Ho	me 5 X Residence 28d. Describe how in	6 ☐ Other (Specif	y)
ion	ending sath. or: Affe he fund	ation	2 Accident investigation	onth, Day, Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		gary coodinou	
Division of	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director; to	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined bu	ce of Injury - At home, farm, stri Iding, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rura ate)	l Route Number,
	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical (	Wedical Examiner: On the	he best of my knowledge, death basis of examination and/or in anner stated.	L h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
_	Voithii comp	M	29b. Signature and title of certifier	mp.	29c. License number	29d.	Date signed (Month,	Day, Year)
			CO Name and addition of the		1004636		1-1-20	08
	\		30. Name and address of person who completed ca	Montclaire	Aue Frederick	mD 21	701	
	Sta Registra		31. Date filed (Month, Day, Year) 32	gistrar's Signature	perti			

08-05466 Stanley J. Langley

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 23920

tarney o. Lange	٠,	1-For State Control of Pearline 11 The air Certificate of Death			ے U U ی. No.	10 2332
Physicia Medical Exami		Decedent's Name (First, Middle,Last)     Stanley J. Langley		2. Date of Death Month July 16, 20		3. Time of Death 1235 hrs
FC1	ilei		own, or Location of Death	July 16, 20	4c. County of Death	
		Potomac River Marsh			Charles	
Funeral Director		5. Social Security Number 212-76-6458 6. Sex 1 Months 21 F 7. Age (In yrs. last birthday) F 1 Months		_	(MM/DD/YYYY) 9. Bir Foreig 3,1957	
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryland 28a-f show	ō	MD Charles Indian Head				1 Yes 2 X No
e Mary	Director	10e. Street and Number 10f. Zip 0		109	g. Citizen of What Cou	ntry?
death with the Maryland or items 23a or 28a-f sho			0640 nt of Hispanic Origin? ( Sp	pecify Yes or No-	USA 14. Race - Amer	ican Indian, Black,
5-0036 led within 72 hours after death with the Maryland itygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify	Cuban, Mexican, Puerto		White, etc.	
rs after	by	or Dates:	X No specify: Decupation (Give kind of w	vork done	Specify: 16b. Kind of Business/	White
5-0036 led within 72 hours at tygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	king life. DO NOT use retir		10b. Kind of business/	moustry
0036 vithin er tha	mpl		penter		Constr	uction
<b>←</b> ≝ □ ≅ ♪	Be Co	17. Father's Name (First, Middle, Last) Joseph Langley	18 Mother's Name Deloris		aiden Surname)	
AD 212 2 should be h and Menta 27 is marke matic even	To E	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address	(Street and Number or F	Rural Route Numb		e, Zip Code)
MD and 2 sho alth and im 27 is			ont Place, I		ead, MD 20	640
Baltimore, permit. Pages I an Department of Hea Important: If iter		1 Burial 2 Cremation 3 Removal from State crematory or other place)	·	Date 7 / 1 0 / 0 0	,	·
Baltim permit. Pa Departmen Important injury or o		4 Donation 5 Other Specify:  21. Signaphyre of Funeral Service Licensee				
Ba Perr Dep Tinju		21. Signature of Funeral Service Licensee M00945 22. AARE AND AND AND ARE AND AND AND AND AND AND AND AND AND AND	RT-ECHOLS FU	nekal Ho ze. La P	JME,P.A. lata.MD	0646
Physician /Medical	П	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line.	dying, such as cardiac of	r respiratory arres	st, shock, or heart	Approximate Interval .  Between Onset and
vaminer			Death			
Power	_	Sequentially list conditions, b				
	aminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or highry that initiated				
ted Insit	Exa	events resulting in death) Last Due to (or as a consequence of):				
760, icate be executed physician and the burial - transit	Medical	X UNPENDED AMENDED 23a,PII,27,28a-f,p	erME, g882	8/7/08 T	T	
760, Treate be		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the			23d. Date of deliver	·
Box 687 ne death certific the attending p	Physician/	past 12 months?  4 Pregnant at time of death 5 Other (Speci	3Ectopic pregna ify)	ancy	Month	Day Year
Bo he deat the at	hys	1 Yes 2 No 9 Unknown g Unknown		Too. Biddel		
ires that the d signed by the	Š	Part II. Other significant conditions contributing to death but not resulting in the underlying a Phencyclidine use	cause given in Part I.		pacco use contribute to	bably 4 🗹 Unknown
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the complete of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con	ompleted	Theneyelldine use		24a. Was a		utopsy findings available
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	dwo			autops perform 1 Yes 2	ned? death?	completion of cause of
tal Reco cian: The law certificate has	Be C		6.Place of Death (Check	1		
Physic Physic er this	٩	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DC	OA Other Nursin		Residence 6  Othe	er: Scene
ion of tending Ph cath.	Ei High	1 Natural 5 Pending (Month, Day, Year)	1 Yes 2X No		drowned	
ivisior  or Attencather death  Director:	ijica	2 X Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory,		28f. Location (St	treet and Number or R	ural Route Number, City
Diversal of neral E	Certification:	4 Homicide determined (Specify) water		or Town, Sta Potomac		sh Hall, MD
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the cone)  Wedical Examiner: On the basis of examination and/or investigation, in my one)				
To T	Medical	and manner stated.	License number		29d. Date signed (Mo	
		(Cantoslesse)	O.C.M.E.		July 17, 2008	
PO		30. Name and address of person who completed cause of death (Item 23a)	Dellimore MD 010	01		
TB Sta	ata		Baltimore, MD 212	UT		
Regist	rar	31. Date filed (Mooth, Pay, Year) 2008 32 Registrar's Signature				

			1 - For State Registrar	State of Mary	yland / Depa <i>Cei</i>	artment of Heartificate of De	alth and Me eath		ne 2008	3 23921
1	Physici	an	1. Decedent's Name (First, Middle, L	-				Date of Death     Month	Day Yea	3. Time of Death 10:00 P M
a la la la la la la la la la la la la la	/Medic Examir		Catherine Mar  4a. Facility Name (If not institution, g.			4b. City, Town, or Loc	cation of Death	July 7,	2008 4c. County of De	
-	handre en en en en en en en en en en en en en	72	1259 Ridge Road			Mt. Airy			Howard	
F 7	Funeral Director		5. Social Security Number 6. 199-22-8610	Sex 7. Age (// 1 ☐ M 2 🛣 F 7.	n yrs. last birthday) Yrs.		fours Min.	8. Date of Birth (Month, Day, Y ${ m Jully}$ 14 ,	ear)	Birthplace (State or Foreign Country) nnsylvania
	and w		Usual Residence of Decedent  10a. State 10b. County	10	0c. City, Town or Lo	cation				10d. Inside City Limits
	Maryl Ff sho fied a	ξŢ	elaware Sussex		Millvill	۵				MXYes 2 No
	or 28s	Director	10e. Street and Number		111111111	10f. Zip Code		10g	. Citizen of What	Country?
	s 23a nust b	eral	11 Dorothy Circle			19970	. 6::: 6:0		USA	
38	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. In marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notifited at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 WNo If Yes, Give Year or Dates:		Nas Decedent of Hispa f Yes, specify Cuban, N I □ Yes	anic Origin? (Spec Mexican, Puerto R Spec <i>ify:</i>	ity Yes or No- ican, etc.)	Black, W	nerican Indian, nite, etc. White
Maryland 21215-0036	in 72 hou n "natura Medical E	Completed	15. Decedent's I (Specify only highest g	rade completed)	16a. Deced	dent's Usual Occupation kind of work done durin OO NOT use retired)	n ng most of working	9	b. Kind of Busine	ss/Industry
212	ed with giene. er than	Som	Elementary/Secondary (0-12)	College (1-4or 5+)		omemaker			Homema	king
and and	be file	Be	17. Father's Name (First, Middle, Las Francis	,		18.	. Mother's Name (	(First, Middle, Ma		
<u> </u>	2 should be and Mental is marked ( aumatic ev	٦	19a. Informant's Name/Relationship	Tracey (Type. Print)	19b. Mailin	g Address (Street and	Sarah Number or Rural	Floute Number (		tine
	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		Joseph M. Marsder			orothy Circ				, 2.0 0000)
Baltimore,	e o == ≥		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3	☐Removal from State	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other place)	Da		c. Location - City	or Town, State
I	permit. Pages Department of Important: If II any injury or o		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice			nore Crem.  . Name and Address of	7/11/2		ewes, DE	no DA
n	Depi Impo any once		1 Beelines			621 Opossum				
			23a. Patt1. Enter the disease, or conshook, or heart failure. List only	nplications that caused the y one cause on each line.	e death. Do not ente	er the mode of dying, so	uch as cardiac or	respiratory arrest	1	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CVA						Onset and Death
	Examiner			Due to (or as a co	onsequence of):					
	pa iis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	onsequence of):					
_e^	xecute and al-trans	Examine	that initiated events resulting in death) Last	c Due to (or as a co	onsequence of):					
0/9 0/9	certificate be executed iding physician and ise as the burial-transit	-Ea		<b>d</b>						
	ertifica ling ph	Medi	IF FEMALE:							
X Q Q	death c aftenc I for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of o Month	lelivery Day Year
	at the c by the tached	hysi	1 □ Yes 2 ZNo 9 □ Unknown	9□Unknown						
coras, r	equires that en signed ould be de	þ	Part II. Other significant conditions	contributing to death but no	ot resulting in the ur	derlying cause given in	Part I.			to the cause of death? Probably 4 DUnknown
Zec Zec	ne law re has be ge 2 sho	Completed						24a. Was an autopsy performe	prior t	autopsy findings available o completion of cause of
N I Cal	an: TI tificate tor, pa	0	25. Was case referred to medical			26	. Place of Death	1□ Yes 2/2	No 1□Y	
> LO	hysic this ce al direc	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatien	t 3 DOA Other:	4 ☐ Nursing Home		e 6 Other (S	Daughter's
	ding F h. After funera	tion:	27. Manner of Death  1  Natural 5  Pending 2  Accident investigation	28a. Date of Injury (Month, Day Ye	ear) 28b. Time of Injury	28c. Injury at Work? M 1 Yes	2 No	d. Describe how	injury occurred	Residence
N N	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Furnatial Director: After this certificate has been signed by the aftending p completely filled in by the funeral director, page 2 should be detached for use as	Certification:	2 Accident Investigation 3 Suicide 6 Could not to 4 Homicide determined	e 28a Place of injuny	At home, farm, stre Specify)			of. Location (Street City or Town, S		Rural Route Number,
	e Hospita 24 hours e Funeral letely filled	edical C	29a. Certifier (Check only one)  Certifying P	hysician: To the best of m miner: On the basis of exa and manner stated	amination and/or inv	occurred at the time, overtigation, in my opinion	date and place, ar on, death occurred	nd due to the caus d at the time, date	se(s) and manner and place, and c	as stated. ue to the cause(s)
	To th withir To th сопр	Me	29b. Signature and title of certifier	. 1 -		29c. License nui	mber	29d	Date signed (Mo	nth, Day, Year)
			offer M	lute 10	)	M0053	3714		7/9/0	8
	\		30. Name and add desp of person who	completed cause of death	(Item 23a) (Type, I	Print)	1. 2M	Borne	mn a	(8)
(5. ) 2. 源	Sta		31. Date filed (Month, Day, Year)	008 32 degistrar's	Signature	who Su	IK GUE	Comme	ט נייין ע	1011
	Registra	ar	JUL I I Z	Della Della	15 149					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05432 State of Maryland / Department of Health and Mental Hygiene 23922 Charles P. Muzzi Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ July 15, 2008 1213 hrs III MUZZI CHARLES √ Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Cecil Chesapeake City 30 Messick Drive 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Min. Months Days Hours MAY 11, 1962 DE 1 X M 2 F 46 221 60 7262 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Yes 2 X No CHESAPEAKE CITY CECIL MD items 23a or 28a-f show ust be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21915 30 MESSICK DRIVE 14. Race - American Indian, Black 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 XXMarried WHITE 2 X No NO Yes 2 X No specify Specify If Yes, Give Year Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Divorced is marked other than "natural", the Medical Examiner ≦ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) ELECTRICAL ENGINEER PROJECT Elementary/Secondary (0-12) ELECTRIC Baltimore, MD 21215-0036 MANAGER 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOAN GLAND CHARLES P. MUZZI, JR. Department of Health and Mental F Important: If item 27 is marked injury or other traumatic event, i Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 30 MESSICK DRIVE, CHESAPEAKE CITY, MD 21915 SUSAN MUZZI - WIFE 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition ALL CONSTRUCTOR PROCEDETERY JULY 2008<sup>21</sup> 1 X Burial 2 Cremation 3 Removal from State WILMINGTON, DE Donation 5 Other Specify. MEALEY FUNERAL HOMES, PO BOX 2866, Signature of Funeral Service Licensee M00784 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line. Death Hypertensive atherosclerotic cardiovascular disease le dical Immediate Cause (Final disease ∡aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last VD The law requires that the death certificate be executed #1 as noted, 23a,27,perME, g882 8/29/08 TT Physician/Medical X AMENDED attending physician or use as the burial -X UNPENDED 23d. Date of delivery Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown the red f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 V Unknown ğ Records, P. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? certificate has 1 1 Yes 2 26 Place of Death (Check only one) 25. Was case referred to medical Physician: **Division of Vital** Be Other4 Residence 6 V Other: Scene Hospital: 1 examiner? DOA Nursing Home 5 ER/Outpatient 3 Inpatient this 1 ✓ Yes 28a. Date of Injury (Month, Day,Year) 28d. Describe how injury occurred 28c. Injury at Work? After 1 To the Hospital or Attending Pt within 24 hours feer ceath
To the Funeral virector: After completely filled in by the funeral 27. Manner of Death Certification: Yes 2 No 1 X Natural Pending 28f. Location (Street and Number or Rural Route Number, City 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 3 Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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ca

State Registrar

31. Date filed (Month, Day, Year)

Theodore M. King, Jr., MD.

29b. Signature and title of certifier

Registrar's Signature

Assistant Medical Examiner

and manner stated

30. Name and address of person who completed carrie of death (Item 23a)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

**OCME** 

29d. Date signed (Month, Day, Year)

July 16, 2008

			1 - State of Maryland /	Certificate of	neaith and ivi <i>Death</i>	ental Hygle Reg.	00 S <sub>«</sub>	23923					
	Physici	an	1. Decedent's Name (First, Middle, Last)			Date of Death     Month	Day Year	3. Time of Death					
	/Medic	cal	Donald Ralph Mulvihill			July	03, 2008	8 1:35 PM					
	Examir	ner	4a. Facility Name (If not institution, give street and number)		or Location of Death		4c. County of Dea						
	Funeral	_	Shady Grove Adventist Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last b		If Under 24 Hrs.	8. Date of Birth	Montgor 9. Bir	rthplace (State or Foreign					
	Director		472-36-8253 <sup>1⊠ M 2□ F</sup> 70	Yrs. Months Days		(Month, Day, Ye May 23,		ountry) innesota					
	and bw		Usual Residence of Decedent           10a. State         10b. County         10c. City, Toy	vn or Location				10d. Inside City Limits					
	Maryl -f sho	ţo		antown				1 1 Yes 2 □ No					
	n the	Director	10e. Street and Number	10f. Zip Code		10g.	Citizen of What C	ountry?					
	th wit	ral	21000 Father Hurley Blvd. #312	208	374		United	States					
	hours after death with the Maryland tural", or Items 23a or 28a-f show at Exartifuer must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Spectar), Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whit						
35	rs afte	by F	If Yes, Give	1 □Yes 2 🛱 No	Specify:		Specify:						
215-0036	2 hou	ted	15. Decedent's Education 16a	a. Decedent's Usual Occu	pation	16b	. Kind of Business	lite /Industry					
7	thin 7 ne. <b>ian</b> "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done life. DO NOT use retire									
7	led wi tygier her th			man Relation	T		Contract	ing					
yland	d be fi ental H red ot c ever	Be c	17. Father's Name (First, Middle, Last)  Ralph Mulvihill		18. Mother's Name		len Surname)						
<u></u>	should nd Me mark mark	၉	A	b. Mailing Address (Street	Grace	Dosh Route Number, Cit	tv or Town State.	Zin Code) 20904					
, Mar	and 2:		Michelle Mulvihill / Daughter 35										
ore,	of He fitem		20a. Method of Disposition 20b. Place of Company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 company 20 com	of Disposition (Name of ery, crematory or other pla			Location - City or						
Ĕ	Pag tment tant: I		I Duna 2 Lacienation 3 D Removal non State	incoln Crema		2008 Bre	ntwood,	MD					
baltimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Marical Expirit net must be notified at once.		21. Signature of Funeral Service Licensee	22. Name and Addre	. 5	imple Tr							
	4-1-6-6		23a Part 1 Enter the disease or complications that caused the death. Do		ville Pike,			0852 Approximate					
	Obvoision	0 0	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Pulmonary Cardiac Arrest 1										
	Physician /Medical		disease or condition resulting in death)  Pulmonary Card:  Due to (or as a consequence					10 minutes					
	Examiner		Acute Penal Fa										
-	ed iit	iner	Sequentially list conditions, if any leading to increasing cause. Enter Underlying Cause (Disease or injury that initiated events resulting death).										
	xecute and I-trans	Examiner	Due to (or as a consequence of):										
0000	e be e sician buria	Na E	Suc to (or as a consequence	oi).									
0	Attending Physician: The law requires that the death certificate be executed redath.  redath.  redath.  redath.  the funeral director, page 2 should be detached for use as the burial-transit.	Medical	d			-	IV.						
5	attendin for use		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	h 3 🗆 Ectopic pregnand	cv		23d. Date of de						
5	ne dea the at hed fo	Physician/	in the past 12 months?  1   Yes   2   No   4   Pregnant at time of death   9   Unknown   9   Unknown	5 Other (specify)			Month	Day Year					
	w requires that the dispersion is been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting i	in the underlying cause gir	ven in Part I.	23e. Did tobaco	o use contribute to	the cause of death?					
<u> </u>	uires n sign ld be	d by		, , , , , , , , , , , , , , , , , , , ,				robably 4 🗹 Unknown					
3	s been	Completed				24a. Was an	ī	utopsy findings available					
֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	: The law cate has l page 2s	mo				autopsy performed	prior to death?	completion of cause of					
<u> </u>	certificate	Be	25. Was case referred to medical examiner?	.,	26. Place of Death		NO   ILITES	s 2□No					
5	Physician: this certific al director,	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/O	dipatient 3 DOA		e 5 🗆 Residence	6 □Other (Spe	ecify)					
5	ding Ph h. After th funeral	ion:	1 ☑ Natural 5 ☐ Pending (Month, Day, Year)	Time of 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injuing 28c. Injui	rk?	3d. Describe how in	jury occurred						
2	Atten death ctor: by the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. At nome, fa		Yes 2 □No	I ocation (Street	and Number or B	ural Route Number,					
5	al or safter safter al Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)	,,,	-	City or Town, St	ate)	arar route rumper,					
	A 1	Medical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
3	vithin To the	Me	and manner stated.  29b. Signature and title of certifier	29c. Licens	se number	29d. I	Date signed (Mont	th, Day, Year)					
•	IVA		Dietas day M.D.	Do	0655 05		Tuly , 3"	, 2008					
7	124.	t	30. Name and address of person who completed cause of death (Item 23a)  QIUTANG CHENG MD 990  31. Date filed (Month, Day, Year)  32. Registrar's Signature	(Type, Print)	^ -	0 0 1	1/-						
	Stat	Α.	QIUFANG CHZNG MD 990 31. Date filed (Month, Day, Year) 32. Raistrar's Signature	" Medical	Center 1	er. Koch	EVITTE, M	עו					
	Registra		1111 1 0 2008 Mayer &	parke									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 2008 Month **Physician** Year July Charles Leazer Main, Jr. 3, 2:11 р /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Anne Arundel
5. Social Security Number Center Medica1 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral Months Days Hours Min 1 X M 2 □ F 264-66-3752 Director 64 9/13/1943 Maryland Usual Residence of Decedent death with the Maryland show 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho Director 1X Yes 2 □ No MD Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5783 Pindell Road 20711 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 MYes 2 No If Yes, Give Year or Dates: 63-65 0.0 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 Is marked other than 'any Injury or other traumatic event, Ire Me any Injury or other traumatic event, Ire Me ones. Elementary/Secondary (0-12) College (1-4or 5+) Electrical 12 Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Charles Leazer Main, Sr. Bessie Amelia Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5783 Pindell Road, Lothian, MD 20711 Elizabeth Main/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/9/08 Chesapeake Crem. Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euroral Service Licensee 22. Name and Address of Facility Raymond-Wood F.H., 108 PO Box 430, Dunkirk, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. the 9 Unknown 9 Unknown signed by t be detach The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 \( \subseteq No 1 ∏Yes 2 ∏No 1 □Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | No 1 Inpatient P 2 ER/Outpatient 3 DOA this To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 14 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated. 29b. Signature and title of cettifie 29d. Date signed (Month, Day,

State Registrar

DRW 10+1

30. Name and address of person wh

31. Date filed (Month, Day, Year)

JUL

completed cause of death (Item 23a) (Type, Print)

32. Registra Signature

2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** Month Facility Name (If not institution, give street and number) 19:04 P M July 05, /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 11XM 2□ F 219-10-6390 84 May 3, 1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9740 H.G. Trueman Road 20657 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Armed Folices: 1 17 Yes 2 | No If 4es, Give Year or Dates: 194546 1 ☐ Never Married 2X Married 1 ☐ Yes 2 📉 No Specify þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Frank Milling Mary Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Ann Milling / Wife P.O. Box 504, Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 07/10/2008 Alexandria, Virginia 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licenses P.O. Box 600, Lusby, MD 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final reumonia disease or condition resulting in death) (or as a consequence of) etestatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23h. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Deen Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Venous 1 Yes 25. Was case re erred to medical examiner? 26. Place of Death Check onl one 2 ER/Outpatient 3 DOA Other: 4 Nursing Home Hospital: Inpatient 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury

certificate be executed nding physician and use as the burial-tran P.O. Box 68760, use as atter for signed by the aid d be detached for Division or Vital Records, has within 24 hours after death.

To the Funeral Director: After this certific.
completely filled in by the funeral director, or Attending

**Funeral** 

**Director** 

show

r 28a-f show notified at

ms 23a or 7

7 is marked other than "natural", or items traumatic event, the Medical Examiner mi

nd Mental Hygiene. marked other than

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traum...

Physician

/Medical

Examiner

death

filed within 72 hours after

3altimore, Maryland 21215-0036

Examiner Physician/Medical þ Completed Be 2 Certification:

5 Pending investigation

6 ☐ Could not be

JUL

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

JUHN 31. Date filed (Month, Day,

4 Homicide

1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Dav. Year)

To the Hospital

State Registrar

Medical

32. Registr s Signature 2008

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:30 William Andrew Norris Ju1<sub>v</sub> 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Leonardtown 40025 Busy Corner Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | November 13,1942 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Mary Land Director 216-40-8274 65 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No St. Mary's Maryland Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40025 Busy Corner Road Funeral 20650 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 📉 No 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No ģ Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Meat Cutter / Butcher Grocery Store is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Calvert Ignatius Norris Mary Elizabeth Gatton ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Helen Rebecca Norris / Wife 40025 Busy Corner Road, Leonardtown, Maryland 20650 20b. Place of Disposition (Name of cemetery, crematory or other place).

Queen of Peace
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 21,2008 Helen, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ohysician Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ∏Yes 2 ∏No has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 100 1 ☐ Yes 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: s after death. 2**/N**0 ٥ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide To the Hospital o within 24 hours aff To the Funeral Di 1 Secritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 062042 0 ~ MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 28103 Three Notch Road, Suite 101, Mechanicsville, Maryland 20659 Karen Bauer, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUL 18 2008

ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000

		1- State of Maryland / Department	rtment of Health and M <i>tificate of Death</i>	ental Hygier Reg. 1	ne 2008 23927				
Physici /Medi		1. Decedent's Name (First, Middle, Last)  Justin William Offutt		Month [	3. Time of Death 3:40 p. M				
Examir		4a. Facility Name (If not institution, give street and number)  10725 Daysville Road	4b. City, Town, or Location of Death  Frederick		4c. County of Death Frederick				
Funeral Director		5. Social Security Number  218-27-4820  Usual Residence of Decedent  6. Sex 1 (IX) 2 F 7. Age (In yrs. last birthday) 18 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day Yes Jan 8, 19	9. Birthplace (State or Foreign Country)  Maryland				
Maryland I-f show fied at	tor	10a. State 10b. County 10c. City, Town or Loc  Maryland Frederick Frederick			10d. Inside City Limits 1				
h with the 23a or 28s st be noti	al Director	10e. Street and Number 10725 Daysville Road	10f. Zip Code <b>21701</b>		Citizen of What Country?				
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by Funeral	1 TANever Married 2 Married 1 TYes 2 TANo	Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 No Specify:  1 □ Yes 2 No Specify:  1 □ Yes 2 No Specify:  1 □ Yes 2 No Specify:						
	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  n/a		ing	Kind of Business/Industry $\mathbf{n/a}$				
uld be fil Mental H Irked oth	To Be	17. Father's Name (First, Middle, Last)  Notley Joseph Offutt, Jr.		e (First, Middle, Maid <b>Lenhart</b>	en Surname)				
ind 2 sho aith and I 27 is ma er trauma	ľ		Address (Street and Number or Run Daysville Road,						
Pages 1 aent of Heart: If item		20a. Method of Disposition  1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)  20b. Place of Disposicemetery, crem  St. Peter			Location - City or Town, State  ysville, Maryland				
permit. Pages 1 Department of H Important: If ite any injury or otl once.		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility Sta 621 Opossumtown P	uffer Fund	eral Home				
ficate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, it any, leading to infinited access. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Small bowel obstruction and perforation  Due to (or as a consequence of):  Multiple, severe congenital malformations  Due to (or as a consequence of):							
w requires that the death certificate been signed by the attending phy should be detached for use as the	Physician/Medi		Ectopic pregnancy Other (specify)						
requires that een signed b nould be deta	by	Part II. Other significant conditions contributing to death but not resulting in the un	o use contribute to the cause of death?						
n: The law re lificate has bee or, page 2 sho	Completed	25. Was case referred to medical		24a. Was an autopsy performed? 1 Yes 2 X					
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification: To Be	examiner?  1 Yes 2 XeNo  Hospital: 1 Inpatient 2 ER/Outpatient  27. Manner of Death  1 Xelatural 5 Pending investigation  3 Suicide 6 Could not be determined  4 Homicide  Hospital: 1 Inpatient 2 ER/Outpatient  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury  28b. Time of Injury  28 Place injury - At home, farm, stre building, etc. Specify)	6 □Other (Specify) jury occurred  and Number or Rural Route Number,						
Hospital or thours afte uneral Dir		29a. Certifier  (Check only one)  1 **ECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							
vithin 24 To the P	Medical	29b. Signature and title of certifier	29c. License number D23651	29d. D	Date signed (Month, Day, Year) 7-10-2008				
\ 	40	31 Date filed (Month Day Year) 32 Prietrar's Signature	hnson Drive, Fred	lerick, Man	ryland 21701				
Sta Registr		JUL 1 1 2008	arle						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 23928

			1 - For State Registrar	Olato or ivit	ary taria / t		tificate of			Reg. No.	000	23320
	Physici	an	1. Decedent's Name (First, Middle, Las						2. Date of De Month		Year	3. Time of Death
	/Media	al		WATERS					07-	09	2008	5:30 A M
	Examir	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Homestead Manor Denton					th	4c. County of Death Caroline			
	Funeral		5. Social Security Number 6. S		e (In yrs. last bii	rthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bir			lace (State or Foreign try)
П	Director		5. Social Security Number 221-09-2321  6. Sex 1 M 2 F P P P P P P P P P P P P P P P P P P						1912		oland	
	and **	Funeral Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits									0d. Inside City Limits
	Manyl -f sho		Maryland Caroline Denton 1□Yes 2XNo									
	th the or 28a ancti		10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?									
	23a c	rai	410 Colonial Dr 21629							US		
	er de	une	11. Marital Status	12. Was Decedent if Armed Forces?		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	⊢ 14.	Race - Americ Black, White,	
936	urs aft	þ	1 ☐ Never Married 2 ☐ Married  ③☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give 1 Year or Dates:		1 ☐ Yes 💥 No Specify:		Specify: white				
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "natural", or fems 23s or 28s-f show ametic event, if a Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working					rkina	16b. Kind of Business/Industry			
121	within ne. han "	mpje	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)				Chir	t Facto	200			
9	Hygie Hygie other I	ပ္ပိ	17. Father's Name (First, Middle, Last)			DCC	IDCL CSS	18. Mother's Na	me (First, Middle,			лу
lan	Aental Aental rked o	To Be	Steven Hrynka					Julie	(Unknown	ı)		
lary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23s or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (				g Address (Street					Code)
ک نه	1 and Health sm 27 Sm 27		Arcy Passwaters -	SON		-	ROSS St	ation Ro	l, Seafor		ion - City or To	um Stato
Baltimore,	ages of of the		1 Burial 2 □ Cremation 3 □		Outemete	ady"	og og og og og og og og og og og og og o				777	
慧	artme ortan injur		*4 □ Donation 5 □ Other (Specify 21. Signature Funeral Samo Ligar		Counce		hurch Ce Cranston		12-2008	Se	cretary	, MD
ä	permi Depa Impo		John A. Crans	ston				967, Sea		1997	3	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between									
Ē	Physician	her	Immediate Cause (Final disease or condition resulting in death)	a ends			Jemer	Hia				Onset and Death
	/Medical Examiner		Due to (or as a consequence of):									
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):									
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	e death	sicia								Month Day Year		
P.O.	res that the de signed by the a be detached f	Phy							23e Did t	I tobacco use contribute to the cause of death?		
Records,	The law requires that the death cerate has been signed by the attendir page 2 should be detached for use	d by							36	1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown		
00	w requir s been si should l	olete							24a. Was	an 2	4b. Were auto	osy findings available
	The law	Completed								osy rmed? 2 No	prior to cor death?	npletion of cause of 2□ No
Division of Vital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?						ath (Check only o	ne)		
<del> </del>	hys this al di	2	1 Tyes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Reside									
o	ng lela line	tion	27. Manney of Death 1 Matural 5 Pending 28a. Date of Injury 28b. Time of Sec. Injury at Work? 2 Accident investigation 28b. Time of Sec. Injury at Work? 1 Yes 2 No								=0-50	
Visi	or Attending after death. Director: Aftel in by the fune	Certification:	a Could be to						28f. Location (Street and Number or Rural Route Number,			
	ital or rs afte rat Dir led in	Cert	4 Homicide building, etc. (Specify)  City or Town, State)									
	9 Hospital or Attendi 24 hours after death 9 Funeral Director: A etely filled in by the fr	edical	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  and manner stated.									
	To the Hospital within 24 hours a To the Funeral Completely filled	Med	29b. Signature and title of certifier	and manner sta	180.		29c. Licens	e number		29d. Date s	igned (Month,	Dey, Year)
3	10-11		•/		- W.	D	Dog	5325	35	7)	10/20	2008
•	usu		30. Name and address of person who of Melina de Bo	completed cause of de	eath (Item 23a)	(Type, F	Print)	e Pres	ston r	ND	216	55
	Sta Registr	_	31. Date filed (Month, Day, Year)	39 Registra	r's Signature	dos	K)					

State of Maryland / Department of Health and Mental Hygiene? 23929 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 2008  $A^{\ M}$ 2:32 July 17 Jane Marie Proctor /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, Aug. 25 9. Birthplace (State or Foreign Country) Virginia 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Vear Months Days 1 □ M 2 💢 F Hours 78 Aug. Director 578-40-3284 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or hitems 23a or 28a-f show ant; It of My and 12 or inclined all any or other traumatic event, It of My and 12 or other death. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U. 21401 S. 2620 Vantage Cove Α. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shumate Rachel Marie Moreland Chancellor ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Arthur Edwin Proctor-husband 2620 Vantage Cove, Annapolis, MD 21401 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or o once. 1 ■ Burial 2 □ Cremation 3 □ Removal from State Arlington National Cem. 09/04/2008 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Moser Funeral Home, Inc. 21. Signature of Funeral Service Licensee 20186 233 Broadview Ave., Warrenton, VA ando in Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ue to (or as a consequence of disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or injury Die to (or as a consequence of) Examiner burial-tran that initiated events resulting in death) Last law requires that the death certificate be execu Due to (or as a consequence of): Box 68760, Physician/Medical the. attending p for use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 5 Other (specify) P.O. ed by the a signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 9 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has page 2 autopsy 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital pital: 1 npatient 2 2 28a. Date of Injury (Month, Day, Year) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 27. Manner of De 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending 1 □Yes 2 □ No ours after death.

neral Director: A
filled in by the fu death. 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely (Check on one) and manner stated. 29d. Date signed (Month, Day, Year) re and title of certifier 29c. License number 29b. Signat 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rul 010 400 mz 48 NOISS 100 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9,2008 Physician 0550 M Francis Μ. Powers /Medical OLU 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico nlisburg ursinac Salisbur KehabarN if Under 1 Year | If Under 24 Hrs. | 8 Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yre last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F 91 Director 719-01-3056 6/16/1917 Maryland Usual Residence of Decedent a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 X Yes 2 ☐ No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4200 Log Teal Drive 20603 USA Examiner must Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 XYes 2 □ No If Yes, Give Merchant Year or Dates Marines 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 XNo Specify. þ Specify: 3 ☐ Widowed 4 ☑ Divorced white Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) brakeman Railroad Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Powers Leah Shewbridge 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 27036 Riverside Dr., Salisbury, MD 21804 Fran Marble/daughter Important: If item 27 any Injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify Salisbury Crematory 7/10/08 Salisbury, MD <sup>22. Name and Address of Facility</sup>
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service L Will Cline. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) QR? /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as the attending IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 10 in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9☐Unknown 9 Unknown É Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: vers after death.

veral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 100 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifiei Medical completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Civic Ave. Salisbury William H. Robins 31. Date filed (Month, Day, Year) State 2008 11 Registrar

DHMH 17 Rev 1/2001

Powers

Francis

08-05298 John Putgenter

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		For State	Certificate o	f Death		Reg.	No. 2 U	
Physician ledical Examine	1.	Decedent's Name (First, Middle,Last)  John Richard Putgenter				July 10, 200		3. Time of Death 0700 hrs
- W. J.	4:	a. Facility Name (if not Institution, give street and number) 3992 Cooks Lane		4b. City, Town, or Ellicott City			4c. County of Deat Howard	
Funeral Director	- 1	. Social sociality reality	n yrs. last birthday) 31 Yr	if Under 1 Yea Months Day		Ain. 8. Date of Birth(100)	MM/DD/YYYY) 9. Bi Forei L926 C	irthplace (State or ign <sup>ountry)</sup> Maryland
death with the Maryland or items 23a or 28a-f show any must be notified at once.	1 1 1	MD Howard  0e. Street and Number  3992 Cooks Lane  1. Marital Status 12. Was Decedent Ev	c. City, Town or Loca Ellicott	City 10f. Zip Code 210	ispanic Origin?	( Specify Yes or No-	Citizen of What Co United St 14. Race - Ame White, etc.	
in 72 hours after han "natural";	<u>-</u>	1 Never Married 2 Married 1 Armed Forces?  1 Yes 2  1 Yes, Give Year 1954  15. Decedent's Education (Specify only highest grade completementary/Secondary (0-12)  College (1-4 or 5+)	No 1-56 1	Yes 2 Nent's Usual Occup most of working lif	o specify: ation (Give kind e. DO NOT use	of work done 1 retired)	Specify.Whit  6b. Kind of Business  Plumbine	s/Industry
ore, MD 21215-0036 ss 1 and 2 should be filed within 72 hou of Health and Mental Hygiene. If item 27 is marked other than "nat her trannatic event, the Myddell East	စ္က	7. Father's Name (First, Middle, Last)  Joseph Putgenter  19a. Informant's Name/Relationship (Type, Print)  Frances M. Putgenter/Wife	19b. Maili	ing Address (Stre	18.Mother's Na Loret eet and Number	ame (First, Middle, Ma ta O'Conno or Rural Route Numb icott City	or or er, City or Town, Sta or, MD 2104	ate, Zip Code)
Baltimore, MD 2 permit Pages 1 and 2 shou Department of Health and 1 Important: If item 27 is 1 injury or other transmit	1	20a. Method of Disposition  1 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee MO1 0 4 4	Meadowri 22 4	other place)  .dge MemName and Addre	Pk. ss of Facility Ha Columbi	7-14-2008 rry H. Wit	zke's Fam	nily FH Ing.
Physician afc.l aminer		23a. Párt I. Enter the disease, or complications thát caused the failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Council of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure	e death. Do not ente ardiovascular D	r the mode of dyin	g, such as cardi	ac or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
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ords, P.C aw requires that nas been signed 2 should be dete	Completed by	Part II. Other significant conditions contributing to death	but not resulting in the			1 Yes  24a. Was a autops perfort 1 Yes 2	2 No 3 F	Probably 4  Unknown  e autopsy findings available to completion of cause of
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No  27. Manner of Death 1 ✓ Natural 5 Pending 2 Accident Investigation 1.2 Inpatier  28a. Date of Injur (Month, Day, Yes)	y 28b. Time	of Injury 28c. I	njury at Work? Yes 2 N	lursing Home 5 1 1 28d. Describe h	Residence 6 🗸 0 ow injury occurred	1
Divisi To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by	ledical Certification:	3 Suicide 6 Could not be determined (Specify)  28e. Place of Injunction  29a. Certifier 1 Certifying Physician: To the best of my one)  2 Medical Examiner: On the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of examination of the basis of examination of the basis of examination	ury - At home, farm, s knowledge, death or hination and/or invest	ocurred at the time	, date and place	or Town, So	e(s) and manner as	r Rural Route Number, City stated. to the cause(s)
To the within To the comple	Σ	29b. Signature and title of certifier  Puntul Youthull Mo  30. Name and address of person who completed cause of de	eath (Item 23a)	29c. Lio O.	ense number			(Month, Day, Year)
Str	ate	Pamela E. Southall, MD Assistant Media 31. Date filed (Month, Day, Year) 32. Restrar	's Signature	111 Penn Str	eet, Baltimo	re, MD 21201		

08-05261 George Proctor

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 23934

		- For State Amend Item	8 per fh,g882 <sub>6</sub> 0	8/14/984	<b>b</b> eath		,,,	Reg. I	No.	
Physician	1/	Decedent's Name (First, Middle,Last)	lichael		Proct	0.5	Mo	ite of Death	ay Year	3. Time of Death 1953 hrs
ledical Examin	•	George IV 4a. Facility Name (if not institution, give str		14		or Location of		y 8, 2008	4c. County of De	
		15971 Woodville Road	cot and name or )		Brandywii				Charles	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Y		24Hrs. 8. [	Date of Birth (N	M/DD/YYYY) 9.	Birthplace (State or
Director	_	218-66-8031 1XM Usual Residence of Decedent	<sub>2</sub> F 53	Yrs.	Months D	ays Hours	Min.	0/03/195 1 0 / 0 3	708	Country Aaryland
any	· -	10a. State 10b. County	10c. City,	Town or Locati	on					10d. Inside City Limits
	5 M	laryland Charle	es		Brar	ndywin	e			1 X Yes 2 No
Maryla 28a-f		10e. Street and Number			10f. Zip Code			10g.	Citizen of What C	ountry?
h the ]		15971 Woodville				513			USA	District Control
th wit tems 2	<b>-</b>	11. Marital Status  1 X Never Married 2 Married	2. Was Decedent Ever in U.: Armed Forces?			Hispanic Origir ban, Mexican, F			White, etc	
ter dea		3 Widowed 4 Divorced If Y	Yes 2 X No	1	Yes 2X	No specify:			Specify: In	merican ndian
urs aft	핡	15. Decedent's Education (Specify only h	Dates:	16a. Deceden	t's Usual Occu	pation (Give ki	nd of work d	one 16	b. Kind of Busine	
72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			life. DO NOT u	ise retired)			m.,
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last)		Proct	or		abet.		den Surname)	Proctor
212 ould be Menta mark	lo Be	Clarence 19a. Informant's Name/Relationship (Type	, Print )	19b. Mailing	Address (St	treet and Numb	er or Rural	Route Numbe	r, City or Town, S	tate, Zip Code)
MD ad 2 sho alth and m 27 is aumati	-1	Thomas Proctor/E	Brother	12250	Crai	n Hig	hway			yland20664
re, l I and FHeal Fitem	T	20a. Method of Disposition  1 Burial 2 X Cremation 3		Place of Dispos crematory or other		•	Dat		0c. Location - City	
Pages		4 Donation 5 Other Specifix		tropo	litan					ria,Virgini
Baltimore, MD 21215-0036 permit, Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signablife of Function Service Licensee	19						eral Ho	
	+	23a. Part I. Enter the disease, or complica		Do not enter the	0605 A	quasco	rdiac or rest	Aqua oiratory arrest	sco, Mar	ryland20608
Physician Medical		failure. List only one cause on each								Between Onset and Death
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74 .	_	Sequentially list conditions, b	. ,	n						
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760, icate be a physicial the buris	Medical		23c. If yes, outcome of preg	nancy					23d. Date of del	ivery
x 687 h certific tending p	~ I	23b. Was decedent pregnant in the past 12 months?	1 Live birth  Pregnant at time of de	oth =	etal death	3 Ectopic	pregnancy		Month	Day Year
Box 687 e death certific the attending ped for use as the	Physician	1 Vee 2 Ne 0 Helmour	4 Pregnant at time of de	eath 5 Ot	her (Specify)					
Records, P.O. Box 68: The law requires that the death certificate has been signed by the attending page 2 should be detached for use as		Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	underlying cau	se given in Par	rt I.			e to the cause of death?
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of Vital Records, ng Physician: The law require there this certificate has been si meral director, page 2 should be	Completed							24a. Was an autopsy	prior	e autopsy findings available to completion of cause of
Recol	Ē							perform 1 Yes 2		Yes 2 No
tal Rection: The	Be C	25. Was case referred to medical examiner?	pital: 1 Inpatient 2			lace of Death (				
1 of Vital Recting Physician: The After this certificate funeral director, page	ટ	1 ✓ Yes 2 No 27. Manner of Death	1 Inpatient 2 28a. Date of Injury	ER/Outpatient		Other <sub>4</sub> Injury at Work?	Nursing Ho		esidence 6 🗸 C	Other: Scene
	<u>ë</u>	1 Natural 5 Pending	Jul 8, 2008	1950 hrs	1	Yes 2	No Sut	ject expos	sed to high er	vironmental
Division tal or Attendi rs after death. al Director: /	اقِ ا	2 Accident Investigation	28e. Place of Injury - At h	ome, farm, stre	et, factory, offi	ce building, etc	28f.			r Rural Route Number, City
Division At ours after desiral Direct filled in by	Certification:	Suicide 6 Could not be determined	(Specify) Mobile Hor				159	or Town, Sta 71 Woodvill	te) e Road, Brandy	wine, MD
	Medical C	one) 2 Medical Examiner: 0	To the best of my knowled the basis of examination a	ge, death occu ind/or investiga	rred at the time	e, date and planion, death occ	ce, and due curred at the	to the cause( time, date an	s) and manner as d place, and due	stated. to the cause(s)
To With	ğ	29b. Signature and title of certifier	d manner stated.		29c. Lic	cense number			29d. Date signed	(Month, Day, Year)
		1 & aurtorla	au )		0	.C.M.E.			July 9, 2008	
	ŀ	30 Name and address of person who con			01 -	141	0.4004			
D02			nt Medical Examiner			altimore, MI	21201 ט			
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signati	H do	arte					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2:30PM lari Zabeth 06 08 /Medical 4a. Facility Name (I not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner the Hospice Lake Salisbu NICOMICC If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 KF 88 225-18-2230 Director 7-20-1919 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic everance. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 No 2 No Director Hecomac hincoteague 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Stree 4196 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: þ White 3 ☐ Widowed 4 MDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be E tta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brad Meadows Exmore, VA Way 20c. Location - City or Town, State 20a. Method of Disposition 1 KBurial 2 ☐ Cremation 3 ☐ Removal from State Medmen 7/10/2008 Cemetery hincotrague, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Chincoteague, UA amanda Botto 6327 Church St Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LIVER MATASTATIC CARCINDUA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of law requires that the death certificate be executed as the burial-tra Due to (or as a consequence of) Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) P.O. the 1 Yes 2-1 No 9☐Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No been signature 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has l autopsy performed After this certificate funeral director, pag 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 A 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: the Hospital or Attending 5 Pending investigation 1 Matural within 24 hours after use To the Funeral Director. Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

All Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

6 Hurin

31. Date filed (Month, Day, Year)

WAR

P.O BOX 1733 SteisBury up 2189

30. Name and and sof person who completed cause of death (Item 23a) (Type, Print)

DASTAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 23936 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** JULY 14, Rowe 12:24 M Grace May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WMHS - MEMORIAL CAMPUS CUMBERLAND ALLEGANY 8. Date of Birth (Month, Day, Nov 12, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** <sup>Year)</sup> 1912 Months Days Hours 1 □ M 2 □ F PA Director 95 215-42-4568 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at 10b. County Allegany Cumberland 1√ Yes 2 No MD Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or Items 23a or 346 Dorn Avenue 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: à white 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be file hand Mental H Julie Jain May Twigg Owen Robert Twigg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) MD 21502 permit. Pages 1 and 2 a Department of Health at Important: if item 27 is any injury or other trau JoAnn Flynn 23 Ridgeway Terrace Cumberland daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 7/16/2008 Sunset Memorial Park MD Cumberland 4 □ Donation 5 □ Other (Specify) 21. Signature of June 1 Sirvice I 22. Name and Address of Facility Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1 Enter the disease, o complica shook, or heart failure. List only one Immediate Cause (Final plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate Interval Between Onset and Death (orona) 5 years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No ed by the a detached f 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy 1□ Yes 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 27. Manner of eath Inpatient 2 ER/Outpatient 3 DOA this funeral Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of it, ry - At home, farm, street, factory, office buildin, etc. ( pecify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760,

al or Attending Patter death.

I Director: After i filled in by To the Hospital or within 24 hours af To the Funeral D

State

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

29a. Certifier (Check only one)

JUL 2 4 2008



The Dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D36766

29d. Date signed (Month, Day, Year)

16,2008

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William Elmer Russell	State of Maryland / Department of Health and Mental Hygiene	-
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2008 239	33	
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			For State Crivial yiand 7 Dep	ertificate of D		a wentan m		20 L g. No.	18 2393
	Physicia	in/	1. Decedent's Name (First, Middle,Last)				2. Date of Death	1	3. Time of Death
Λı .	`al Exami		William Elmer Russell	10	0	Landing of Barth	Month July 15, 20	08 4c. County of Death	1120 hrs
			4a. Facility Name (if not institution, give street and number) 22197 Bay Arbor Way		City, Town, or Great Mills	Location of Death		St. Mary's	
	Funeral				If Under 1 Year	r If Under 24Hrs.	8. Date of Birti	h(MM/DD/YYYY) 9. Birl	hplace (State or
	Director		219-46-8371 1x M 2 F 63		Months Days	s Hours Min.	June 22,	1945 Foreig	n <b>Maryland</b> untry)
	*		Usual Residence of Decedent  10a. State 10b. County 10c. Cit	ity, Town or Location					10d. Inside City Limits
	OW any		Maryland St. Mary's	ty, rown or Location	Cros	t Mills			1 Yes 2 X No
	daryland 28a-f show 1 at once.	턍	10e. Street and Number		Of. Zip Code	L HIIIS	10	g. Citizen of What Cour	
	with the Maryland ns 23a or 28a-f sho be notified at once.	Director	22197 Bay Arbor Way		2063	4		USA	
	more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	If Yes,		panic Origin? ( Sp n, Mexican, Puerto		14. Race - Amer White, etc.	can Indian, Black,
	ter de: ", or i		1 X Yes 2 No 3 Widowed 4 X Divorced If Yes, Give Year		es 2 No	specify:		Specify: Wh:	ite
	urs af Itural	g p	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's	Usual Occupat	tion (Give kind of w		16b. Kind of Business/	Industry
	5-0036 led within 72 hours a Hygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	, i		DO NOT use retir	ed)	m	
	within iene. er tha	틹	12	Truck D			45° 14° 1	Transporta	tion
	21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Last)			18.Mother's Name		,	
	2121 wild be fi Mental marked c event,	To Be	Joseph B. Russell  19a. Informant's Name/Relationship (Type, Print )	19b. Mailing A	ddress (Stree		ret Mary I Rural Route Num	NOTT1S ber, City or Town, State	e, Zip Code)
	MD d 2 sho lth and n 27 is numati		Dawn Hierstetter / Daughter	18459 Wi	ndmill P	oint Rd.	Drayden, l	MD 20630	
	nore, MD 2 ages 1 and 2 shou nt of Health and N it: If item 27 is n other traumatic			b. Place of Disposition		* 1	Date <b>y 18,</b>	20c. Location - City or	Town, State
	Pages tent of mt: 1		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	etropolitan		у	2008	Alexandria,	Virginia
	Baltimore, permit. Pages I as Department of Her Important: If ite		21. Signature of Funeral Service Licensee	Ma	ne and Address	-Gardiner 1	Funeral H	ome, P.A.	
		]	23a. Part I. Enter the disease, or complications that caused the dea	P.	0. Box 2	70 Leonard	dtown, MD	20650	Approximate Interval
	Physician Medical		Mailure. List only one cause on each line.		mode of dying,	30011 23 0314.00 0	, roopiidiory arre		Between Onset and Death
_	_xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Contact Gunshot Wood Due to (or as a consequence or condition resulting in death)						
			Sequentially list conditions, b						
		niner	if any, leading to immediate Cause. Enter Underlying Cause	e of):					
	ecuted and transit	Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence d.	e of):		<del></del>			
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	Box 687 e death certific the attending	ysį	1 Yes 2 No 9 Unknown g Unknown	o oule					
	<b>P.O.</b> rires that the signed by t	by Phys	Part II. Other significant conditions contributing to death but no	ot resulting in the unc	lerlying cause	given in Part 1.		obacco use contribute to s 2 ✓ No 3 Pro	
	duires en sign	ted			··		24a. Was		utopsy findings available
	cords law requi	Completed					autop		completion of cause of
	tal Rection: The certificate ector, page	S					1 🗸 Yes	2 No 1 Y	es 2 No
	Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2	ER/Outpatient		Other Nursir		Residence 6 ✓ Othe	er Scene
	ing Phys After thi funeral di	<u>은</u>	27 Manner of Death 28a Date of Injury	28b. Time of Inju		ry at Work?	28d. Describe	how injury occurred	
	ion of tending eath. tor: At	흲	1 Natural 5 Pending FOUND: Poly Year) 2 Accident Investigation Jul 15, 2008	FOUND: 1108 hrs	1	Yes 2 V No	Subject sho	t self	
	Division of Vital Records, ral or Attending Physician: The law require is after death.  al Director: After this certificate has been silled in by the funeral director, page 2 should b	iji E	2 Accident Investigation Jul 15, 2008 3 Suicide 6 Could not be 28e. Place of Injury - A		factory, office I	building, etc.	28f. Location (S		ural Route Number, City
	Division Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	Certification:	4 Homicide determined (Specify) Single F	amily			22197 Bay Ar	bor Way, Great Mills	, MD
5	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Medical (	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination	ledge, death occurre in and/or investigatio	d at the time, d n, in my opinio	late and place, and n, death occurred a	I due to the caus at the time, date	se(s) and manner as sta and place, and due to t	ted. he cause(s)
	To To cor.	Mec	29b. Signature and title of certifier		29c. Licens	se number	-	29d. Date signed (Me	onth, Day, Year)
			Janh Georms		O.C.	M.E.		July 16, 2008	
			30. Name and address of person who completed cause of death (It	,	-			J	
			Tasha Greenberg MD. Assistant Medical Exa		enn Street,	Baltimore, Mi	D 21201		
	S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registrar's Sign	lature					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** George E. Ritter, Jr. July 8, 3:00 a M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 4217 Hillcrest Ave. Hampstead If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/08/1936 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1√2 M 2□ F MD **Director** 249-66-1681 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County items 23a or 28a-f show Examiner must be nuffled of 1 ☐ Yes 2√2 No Director MD Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21074 USA 4217 Hillcrest Ave. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1√2Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐Yes 2√2 No Specify. Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 home improvement Paper hanger Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Maxine Ridenour George E. Ritter, Sr. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sherry Carter - Sister 1703 Lake Forest Drive, Finksburg, Md. 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Carroll Cremation Hampstead, Md. 7/8/2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility m00741 Eline Funeral Home Lemmer 934 S. Main St., Hampstead, Md. 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastatic disease or condition resulting in death) /Medical Que to (or as a consequence of): 4.00 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Be Completed by Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 / N 1 ☐ Yes 2 1No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No Medical Certification: To 5 Nesidence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier (Check only one) and manner stated 29b. Signature WJZ 3tIVA (Item 23a) (Type, Print) 30. Name and addr Street Westminster South KODER 31. Date filed (Month, Day)

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup>2008 **Physician** JULY 6, 11:15A M DAVID WHITTIER ROESE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE'S CENTREVILLE HOSPICE HOUSE CENTREVILLE 5. Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, **Funeral** Months Days Hours 1 X M 2 □ F PA Director 82 11/24/1925 190-20-7047 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural", or Items 23a or 28a-f show traumatic event, the Medical Evantiner must be notified at Director 1 ☐ Yes 2 X No CATONSVILLE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5807 IVY LEAQUE DR. 21228 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1XYes 2 □ No Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Year or Dates: WWII Specify þ Specify: WHITE 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ SCIENTIFIC ENGINEER ENGINEERING marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t and 2 should be fill Health and Mental H tem 27 is marked ott Be JOHN A. ROESE EDITH A. HOBE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN ROESE/DAUGHTER 5807 IVY LEAOUE DR. CATONSVILLE, MD 21228 injury or other permit. Pages 1 and Department of Heal Important; If Item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 7/10/2008 STEVENSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 'n FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Pulmorus Diseare Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-t Box 68760 Physician/Medical SE IF FEMALE use ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a Ö ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an Jas certificate Vita 2 No 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hos Rice Facility Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Natural 5 ☐ Pending investigation death. rector: / 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Dire 4 T Homicide within 24 hours a

To the Funeral I

completely filled the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 30. Name and address of person who comp ted cause of death (Item 23a) (Type, Print) Muthen King Chesteran, no 21620 31. Date filed (Month, Day) State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8

		1	State of Maryland / De	partment of Health and Me ertificate of Death		giene 2008 leg. No.	23940
Phys /Me	sicia: edica	n	Decedent's Name (First, Middle, Last)     Herbert S. Russell		2. Date of Dea Month June	Day Year 27, 2008	3. Time of Death
	mine		4a. Facility Name (If not institution, give street and number)  Calvert Memorial Hospital	4b. City, Town, or Location of Death Prince Frederick		4c. County of Deatl	1
Funer Direct			5. Social Security Number 6. Sex 7. Age (In yrs. last birthdt  215-26-3488 78 Yrs	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day Novembe		nplace (State or Foreign untry) yland
Maryland -f show fied at			Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or           MD         Calvert         Lusby	Location			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
h with the 23a or 28a st be noti	i	5	10e. Street and Number 8265 Sycomore Road	10f. Zip Code 20657	1	10g. Citizen of What Co	untry?
ine, with yearly and 2 IZIS-DOOOO  s 1 and 2 should be filed within 72 hours after death with the Manyland if Health and Mental Hygiene. them 21 is marked other than "natural", or items 23a or 28a-f show offent fraumatic event, the Medical Examiner must be notified at		by Funeral		Was Decedent of Hispanic Origin? (Spenif Yes, specify Cuban, Mexican, Puerto F     □ Yes 2 No Specify:	cify Yes or No- Rican, etc.)	Specify:	
vithin 72 houndline.		Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation we kind of work done during most of working DO NOT use retired)	g	16b. Kind of Business/l	
be filed w ntal Hygie ed other the		å n	17. Father's Name (First, Middle, Last)	Traffic Controller Assistant 18. Mother's Name			<u> </u>
id 2 should the and Mei	,	2 -		illing Address (Street and Number or Rura	Route Numbe		lip Code)
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau			20a. Method of Disposition 11 Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Di cemetery, 0	O Hatteras Circle, Waldorf, Months of Position (Name of Paratory or other place)  am Veterans Cem. 7/8/20(	ate	20c. Location - City or	
permit. Departm Importal any inju	ouce.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility ewell Funeral Home, P.A., 1451		Cheltenham, M	
Physicia /Medic Examin	al		Due to or as a consequence of):	Infarction/Cardi			Approximate Interval Between Onset and Death
\$ #		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):	ronay Arteny d	islas	L	
ficate be executed physician and sthe burial-transit		dicai		Se We-		70	
o the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.  o the Funeral Director: After this certificate has been signed by the attending physician and rempletely filled in by the funeral director, page 2 should be detached for use as the burial-transit		Pnysician/ine		B□Ectopic pregnancy 5□ Other (specify)		23d. Date of del Month	ivery Day Year
requires that the de sen signed by the a lould be detached f		2	Part II. Other significant conditions contributing to death but not resulting in the End Stage Renal disease	on boundialis	23e. Did to	obacco use contribute to ′es 2 □ No	the cause of death?
an: The law tificate has b		е сошріетеа	Aortic Dissection - Type 25. Was case referred to medical	e TTL  26. Place of Death		rmed prior to death?  2 No 1 □ Yes	topsy findings available completion of cause of
g Physicia er this cer eral direct	i i	0	examiner?  1  Yes	ient 3 DOA Other: 4 Nursing Hon	ne 5 Resid	lence 6 Other (Special own injury occurred	cify)
To the Hospital or Attending Physician: The law requir within 24 hours after dearh. To the Funeral Director. After this certificate has been si completely filled in by the funeral director, page 2 should		Certification:	Accident 5 ☐ Pending investigation 3 ☐ Suicide 4 ☐ Homicide	M 1 Yes 2 No	8f. Location (S City or Tow	Street and Number or Ru n, State)	ıral Route Number,
te Hospita 124 hours te Funeral		legical C	29a. Certifier (Check only one)  Check only one)	path occurred at the time, date and place, a investigation, in my opinion, death occurred	and due to the ded at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
To the		Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mont	
RW) 2+	State		30. Name and address of person who completed cause of death (Item 23a) (Ty)  Enwyneth Blattau, im 110 tospital Ro  31. Data tied (Month Day, Year)  32. Benistra Signature	DS8572 et#310 Prince Frederic	demo	20678	Politi Usassass
	istra	-	JUL 2 2008 Januar &	& Sparke			

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** <sup>Day</sup> 2008 JULY PAUL GERARD SWOPE 17 5:30P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 622 CURRANT COURT LA PLATA CHARLES 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2-22-1931 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 1**∑**M 2□ F 395-26-9321 IDĂĦŎ Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10a State 10h County MD. CHARLES LA PLATA 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 622 CURRANT COURT 20646 U.S.A. ns 23a c permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must once. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 DX es 2 □ No NAVY If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: WHITE 3√2 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) CLEARWATER NATURE Elementary/Secondary (0-12) College (1-4or 5+) NATURALIST CENTER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN HELEN BROWN ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VICKY GREER-DAUGHTER P.O.BOX 14 WELCOME, MD. 20693 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State UNITED METH.CEM. 7-22-08 DENTSVILLE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice M00479 RAYMOND FUNERAL SERVICE, P.A. PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and e burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical phys the t attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown Day 5 ☐ Other (specify) 2 □ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Linknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autonsy perform aZN. 1□ Yes To the Hospital or Attending Physiclan: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Tyes 2 No Other: 4 Nursing Home 5 Presidence 6 Other (Specify) ۵ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of confiier 29c. License number 30. Name and addres person who completed cause of death (Item 23a) (Type, Print) Pι 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5:12 A. Shaffer 2008 Frances JULY 16, /Medical Mary 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ALLEGANY CUMBERLAND MEMORIAL HOSPITAL cocial Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan 16, 1925 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2√F ΚΥ Director 83 218-16-<del>4</del>610 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits show an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at Allegany Cumberland Y⊟Yes 2 □ No MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21502 1 Baltimore Street Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If Item 27 Is marked other than "natural", or Ite 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white Completed by 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the own home 12 homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie B. Redmond Seymour David C. Seymour ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
415 Washington Street Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) 415 Washington Street Cumberland Julia Pariser sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of himportant: If Ite any Injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State SS Peter & Paul's Cemetery 7/18/2008 Cumberland MD 4 □ Donation 3 □ Other (Specify) 21. Signature of Funeral Senice Lice 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock or head failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Immediate Cause (Final **Physician** *ioronar* disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, and a sequentially list conditions, as the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the buriat-tran Division or Vital Records, P.O. Box 68760,5 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 27 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To after death.

I Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive, Cumberland, Ma 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

JUL 2 4 2008

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 18 200 8 a JÜĽŸ JOHN LESLIE SLAGLE 2:25 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Chestertown Nursing & Rehab Chestertown Kent 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours Days Min. 1⊠M 2□ F 217-28-4029 76 14 1932 Maryland Director May Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City. Town or Location 10b. County 10d. Inside City Limits items 23a or 28a-f show iner must be notified at 1 Yes 2 No Directo Queen Anne's Chestertown MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 339 Longfellow Dr. 21620 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No 1953 If Yes, Give Year or Dates: -1955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White þ 3 ☐ Widowed 4 ☑ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Petroleum Carrier 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Charles P. Slagle Catherine Dickerson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Bennett (daughter) 992 Cox Neck Rd. St. Georges, DE. 19733 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Chester Cemetery 7/23/08 Chestertown, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Galena Funeral Home of Stephen L Schaech M00510 118 West Cross St. Galena, MD. 21635 23a. Part Inter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sr ock, or h art failure. List only one cause on each line. Immediate Couse (Final disease or condition **Physician** 294a Mous Cell disease or condition resulting in death) /Medical Du to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Metastatic Viseuse to Brain, Previous Squamous Cell 1 Yes 2 No 3 Probably 4 Unknown Completed Cancer of Neck, HTN, Dyshipidenia, Pacemaker, Coronary Arten Disease, Carotil Stenosis 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 25. Was case referred to me, examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes £ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Deal 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 Accident 1 Tyes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Kind

JUL 2 4 2008

MD

Matthew J.

31. Date filed (Month, Day, Year)

1D 120 Speer Rd. Chestertown, MD.

2. Registrar's Signature

21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 6,2008 Year 6:00 PM Jean M. Sherlock 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center for Hospice Care Towson 8. Date of Birth (Month, Day, Year)
November 28, 1922

Pennsylvan a If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 K F 211-22-6714 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 No Maryland Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 21229 566 South Beechfield Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Š 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertha E. Stringer James M. Sherlock, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17082 19a. Informant's Name/Relationship (Type. Print) 727 Half Moon Road, Port Royal, Pennsylvania James M. Sherlock, Jr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 15 ☐ Other (Specify) 7-9-08 Baltimore, Maryland Bayview Crematory 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee michael 1. marzullo 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ue to (or as a consequence of): WEEKS disease or condition resulting in death) Securations list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ducase Coronary differse 1 Yes 2 No 3 Probably 4 Unknown ander discourt 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only onle) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) WOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles ST TONISON MO 21204 CHALVES m AMON

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

32. Registrar's Signature

DHMH 17 Rev 1/2001

**Physician** 

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Evander must be notified at once.

Physician

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 2008 Year Рм **Physician** 2:10 July 15, Elizabeth Hunt Sterling /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Leonardtown St. Mary's St. Mary's Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 29,1924 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min Months Hours 1 □ M 2 🖾 F Maryland 83 Director 212-24-4658 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ire Medical Evanime must be unfifted at once. 1X Yes 2 No Director St. Mary's Leonardtown Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 22945 Abell Street 20650 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maria Greenwell Robert M. Hunt ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Harris Sterling / Son 21820 Rosebank Court Leonardtown, MD 20650 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 18 Leonardtown, Maryland St. Aloysius Cemetery 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Foneral Service Licensee Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 m Approximate Interval Between Onset and Death 23d. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** NOU disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 ☐ Other (specify) rate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 1 ☐Yes 2 ☐No this certificate 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After th funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending nours after death. neral Director: Aff illed in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7.16.08 30. Name and address of person who completed dause of death (Item 23a) (Type, Print)
William D. Boyd, II 23565 Pt. Lookout Road Leonardtown, MD 20650 31. Date filed (Month, Day, Year) Registrar's Signature State JUL 1 6 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** July 2008 11 2:15 am Ida Pear1 Sullivan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's 22680 Cedar Lane Court, Apt. 2108 Leonardtown
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Hours 1 M 2 ▼ F Months Days 09/20/1918 New York Director 008-24-9597 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director Maryland St. Mary's Leonardtown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 22680 Cedar Lane Court, Apt. 2108 20650 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo if Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced "natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse 4 Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental I Item 27 Is marked o r other traumatic eve 1 and 2 should be Health and Mental 2 Ruth Gladys Howard George LaVentura 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6035 Swanson Creek Lane, Hughesville, MD ace of Disposition (Name of Date 20c. Location - City or Tow Dianne Pellettiere/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages permit. Pages Department of Important: If Its any Injury or o 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 07/12/2008 | Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Was Softage Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. REMAL Immediate Cause (Final FAILURE years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): THRIVE ANEMIA Examiner URE Esquentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ed by the detached or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by THRIVE ANEMIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an has autopsy performed? res 2 No certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၀ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: To the Hospital or Attending Division 1 Natural 5 Pending investigation within 24 hours and worth To the Funeral Director; Af 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0051738 11, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KAE T. AUNG, 24435 MERVELL DEAN RD. HOLLY WOOD, MD 20636 32. pgistrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 008 23947 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Vear **Physician** Month 12:45 P M 9, Freda N. Shriver July 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Homewood at Crumland Farms Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛚 F 220-42-5991 Yrs. Director 88 May 7, 1920 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r 28a-f ahow 10d. Inside City Limits 1 Yes 2 No Director Maryland Frederick Knoxville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a or the Medical Examiner must be 744 Jefferson Pike 21758 United States Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No ģ Specify: White 3 □ Vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within 7;
Depertment of Heelih and Mental Hygiene.
Important: If itam 27 is marked other than "ns any injury or other fraumatic event, tra Medie 2006. Elementary/Secondary (0-12) College (1-4or 5+) 12 Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Paul Gaither Ruth Barger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Virts / Daughter 744 Jefferson Pike, Knoxville, MD 21758 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) Lovettsville Union 7/12/2008 Lovettsville, Virginia 21. Signature)of Funeral Service Licensee Stauffer Funeral Home 22. Name and Address of Facility Part 1. Enter the disease, or complications that knused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, anck, or heart failure. List only one cause on each line. 1621 Opossumtown Pike, Frederick, MD 21702 Approximate Interval Between Onsetland Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, I any, loading to initial ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes -2 No 100 : After this certifications a funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending efter death. I Director: Aff d in by the fur investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 0 within 24 hours e To the Funeral C Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states. Medicai 29a. Certifier (Check only one) 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month, Day, Year) no completed cause of death (Item 23a) (Type, Print) Name and address of person 9th St. Frederick, mo 31. Date filed (Month State Registrar

Baltimore, Maryland 21215-0036

Box 68760

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Division of Vital Records.

Library to Physicians

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 3. Time of Death 2. Date of Death edent's Name (First, Middle, Last) SANTACROCE Month 07 **Physician** BNOHT ST. 2010 M /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Anne Arundel Harwood Mandrin Hospice House If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Sex 12 M 2□F Funeral Months Days Hours Min Yrs. 7/4/1926 New York Director 112-16-0970 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ▼No Director Maryland Prince George Upper Marlboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20772 12104 Northwood Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Mayes 2 No WWII If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If flem 27 is marked other than any Injury or other transment. Elementary/Secondary (0-12) College (1-4or 5+) DC MPD PoliceOffier 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cutrone Carmela SantaCroce Ralph ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5715 Courtney Drive Lothian, Md. 20711 Donna S. Jackson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) Entombment Cedar Hill Cemetery 7/11/2008 Suitland, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home Funeral Service Licensee 21. Signatur 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part. Enter the disease shock, or heart failure. e, or complications List only one daus Immediate Cause (Final disease or condition resulting in death) 24 Due to (or 's a co sequence of): **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) been signed by the s 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s perform 1 Yes 2 No 1 + touse Hospite director. 25. Was case referred to medical 26. Place of Death Check onl one Be 6 Dother (Specify) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA After this Medical Certification: To 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury at Work? 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident

Division or Vital Records, P.O. Box 68760, or Attending Physician:

within 24 hours after death

To the Funeral Director: A To the Hospital

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) stated 29d Pate signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

3 ☐ Suicide

4 Homicide

6 Could not be determined

of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

EFENSE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1CHAQ 31. Date filed (Month, Day, Year)

2008

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State

Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Sidondra July Elizabeth Savoy 2008 9:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9160 Chapel Point Road Bel Alton Charles | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 3 / 1 8 / 1 9 6 1 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2**X** F 219-80-3204 47 Yrs Washington DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10a. State 10b. County 1 XYes 2 No Bel Alton Director Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with ural", or Items 23a o I Examiner must be 20611 9160 Chapel Point Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married  ${\it Specify:} {\color{red} Native}$ 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 A Divorced American 'natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event. The Me Elementary/Secondary (0-12) College (1-4or 5+) Data Management Catapult Technology 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mason Mervine 198 Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mervine Mason/ Mother Upper Marlboro, Maryland 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/15/08 Clinton, Maryland Resurrection 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Funeral Home PA 21. Signature Juneral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. 20605 Aquasco Rd. Aquasco, Maryland 20608 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a sum quence of): Examiner the death certificate be executed burial-transi and Due to (orus a consequence of): P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy for Month in the past 12 months? Day Year 1 Yes 2 No 9 Unknown 5 ☐ Other (specify) detached the signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, pe 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performes certificate 1∐ Yes 2√∑No Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After completely filled in by the funera Certification: or Attending 5 Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 🗡 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier address of person who completed cause of death (item 23a) (Type, Print) 5. OSBOTATE 1611 816 106 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	•	Ce	ertificate o	f Death					Reg. N	o. Z	UUE	3 23	3951
Physicia	in/	1. Decedent's Name (First, Midd							2	2. Date of De Month				Time of Dea	
edical Exami	ner	Sheila Ter								July 9, 2	800			1039 hrs	
A Sec.		4a. Facility Name (if not instituti Chester River Hospit		mber)		4b. City, Tov Cheste		ocation of	Death			4c. County Kent	of Death	-	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under	_	If Under		8. Date of	Birth(M	M/DD/YYYY	g. Birthp Foreign	lace (State o	r
Director		214-78-7294	1M XXF	48	Yr	Months s.	Days	Hours	Min.	5/1	7/1	960	Coun	try) MD	
· w	:	Usual Residence of Decedent  10a. State 10b. County	,	10c. Cit	ty, Town or Loca	ntion							1	0d. Inside Cit	ty Limits
P P P		MD Ken	t	Che	esterto	own								Yes 2	No
arylan Ba-f si at one	윉	10e. Street and Number				10f. Zip C	ode				10g. C	itizen of W	hat Countr	y?	
th the Maryland 23a or 28a-f show any notified at once.	Director	23160 Baywoo	od Ct Api	t 16D		21	620					USA			
1 with ms 23 be no	era	11. Marital Status		edent Ever in		as Decedent Yes, specify					No-		e - America le, etc.	n Indian, Bla	ck,
r deatl	Funeral	1 Never Married 2 X	1 Yes	2 X No			UT.		00.00	10011, 0101)				ack	
s after	۵		ivorced If Yes, Give Yea			Yes 2		specify:	nd of we	ork done	1161	Specify: b. Kind of Bu			
2 hour "natu Exar	ted	15. Decedent's Education (Sp Elementary/Secondary (0-12				most of working					100	. rang or be	Q3/11/C33/11/C	·	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Completed	17. Father's Name (First, Middle	e, Last)							First, Middle			9)		
121   be fill ental F urked	a	John Henry I							200	an K					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	욘	19a. Informant's Name/Relation George T. Se	iship (Type, Print)		19b. Mailii 2316	og Address 00 Bay	(Street a	and Numb	erorRu t A	ral Route N pt 1	lumber, 6 D	City or Tov Ches	wn, State, 2 tert		<u>¥</u> B
e, N and 2 Health item 2		20a. Method of Disposition		201	D. Place of Dispo	sition (Name	of ceme	etery,		Date	20	c. Location	- City or To		20
Baltimore, permit. Pages 1 an Department of Hea important: If iten njury or other tr		1 Burial 2 X Crematic		om State	crematory or capitol	Cren	nato	ory	7 /	19/0	8 D	over	, DE		
Baltin permit. P Departme Importar injury or		4 Donation 5 Other S 21. Signature of Funeral Service			22.	Name and A	ddress o	of Facility							
ii.i. Per De		Monnie U	+ Sha	W	₽ 8	nnie ver,	BE I	ifh9	54n	eral	Но	me 7	17 W	. Div	isio
Physician		23a. Part I. Enter the disease, of failure. List only one caus	r complications that c	aused the dea	th. Do not enter	the mode of	dying, s	uch as car	rdiac or	respiratory	arrest,	shock, or he	eart	Approximate Between Or	Interval
/Medical -xaminer		Immediate Cause (Final diseas	e a Mixed	drug (	tramado	1, nor	tri	ptyli	ine	& сус	1obe	enzapi	rine)	Dear	th
		or condition resulting in death)	Due to (or as a	consequence	of): <b>intox</b>	cicatio	n								
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence	e of):										
_	힐	cause. Enter Underlying Cause (Disease or injury that initiated	C.		of):										
uted d ansit	Exa	events resulting in death) Last	d.	consequence	s 01).										
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760, ficate be g physicii the buri	/Me	IF FEMALE: 23b. Was decedent pregnant in		outcome of pr	egnancy	etal death	2	Ectopia	nroanar	2014		23d. Date of Month			rear
30x 68 death certiff e attending for use as	ciar	past 12 months?	LIVE L	nant at time of	donth	-etai death Other (Specif		_ Ectopic	pregnar	СУ	1	Monun	06	'y '	Cai
Box 68 e death certifi the attending ed for use as t	Physicia	1 Yes 2 No 9 🗸 U	nknown 9 Unkn	own											
s, P.O. Box 68 irres that the death certiful signed by the attending the detached for use as	by P	Part II. Other significant cond	litions contributing to	o death but no	t resulting in the	underlying c	ause giv	ven in Par	t I.			_		e cause of d bly 4 ✔ U	
										24a. W				psy findings	
Division of Vital Records, read or Attending Physician: The law required in the law required or and the restoration of the restoration of the restoration of the restoration of the restoration of the funeral director, page 2 should led in by the funeral director, page 2 should	Completed									au	as an utopsy erformed			mpletion of c	
Rec The licate h	Com									1 🗌 Ye	es 2 🗸		1 Yes	2	No
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f Vit Physic er this	٢	1 ✓ Yes 2 No 27. Manner of Death	28a. Date		✓ ER/Outpatie 28b. Time o		··	at Work?		Home 5 28d. Descri		idence 6	Other:		
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isior Attend er death rector: by the	icat	2 Accident Inv	estigation Fnd	7/9/08_ ce of Injury - A	9:43 a t home, farm, str		office bu	ilding, etc			n (Stre	et-and-Num	per er Rur	L Route Nur	ber, City
Division At ours after dours after diffled in by	Certification:		uld not be termined (Specify)	foun	d at ho	me				or Tow				Boota Nuc	L. Ku
Division  To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: A completely filled in by the fi		29a. Certifier 1 Certifying	Physician: To the be						ce, and	due to the c	ause(s)	and mann	er as state		
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Ex	aminer: On the basis and manner s		n and/or investig	ation, in my o	opinion,	death occ	curred at	the time, d	ate and	place, and	due to the	cause(s)	
	Š	29b. Signature and title of certif	fier	^			License							th, Day, Year)	
		facil	L- Kol	De v	~		O.C.N	1.E.			J	uly 10, 2	.008		
		30. Name and address of person				111 Do	nn Str	oot Rai	ltimore	e, MD 21	201				
		Patricia Aronica-Poll		eg trar's Sign	al Examiner	iiirei		eel, Ddl	iannoi e	, IVID 21	201				
Si Regis	tate trar	31. Date filed (Month Pay Yea	1 4 2008°	Eleve	K A	book	,								
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)	Physicia /Medic Examin	al
	Funeral Director	

			1 - For State Registrar	Ctate of Maryla	-	tificate of		Reg	1. No. 2008	3 23951	
	Physici	ian	1. Decedent's Name (First, Middle, Las	•				2. Date of Death Month	Day Year	3. Time of Death	
<b>V</b>	/Medic Examir		Paul Woodrow Sev  4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	July	11 2008 4c. County of Death		
)	e -		Ravenwood Luther			Hagers			Washing		
	Funeral Director		214-09-9341	ex 7, Age ( <i>in yr</i> s	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 03/28/19	0 Diet	hplace (State or Foreign untry) MD	
	land ow		Usual Residence of Decedent  10a. State 10b. County		Cify, Town or Lo	cation				10d. Inside City Limits	
	a-f sh	ctor	MD Washing	gton	Hagerst	own				1XYes 2 No	
	th with the 23a or 28 ast be not	Funeral Director	10e. Street and Number 12 S. Walnut Str	reet		10f. Zip Code 2174	.0	10g	. Citizen of What Col	untry?	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hylgiene. Department of Health and Mental Hylgiene. In protratist if items 23 a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 ☑ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	e, etc.	
ָה ה	"natu dical	letec	15. Decedent's Ed (Specify only highest gra	fucation ade completed)	16a. Deced	lent's Usual Occup kind of work done	pation during most of worki d)	ng [	6b. Kind of Business/I	ndustry	
717	within iene. than the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	nipping	a)	I .	Cabinet Ma	nufacturing	
ana	e filed al Hygi other vent, t	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name			1101000011118	
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e, Mar 1 and 2 sh Health and em 27 is n ther traun			19a. Informant's Name/Relationship (	/ Nephew	1301	lvania Av		City or Town, State, Z			
ore	iges 1 nt of Hi or oth		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐			sition (Name of natory or other place			c. Location - City or 1		
pairimor	nit. Pa artmer ortant: injury	1	4 □ Donation 5 □ Other (Specify 21 Size ature of Filth ral Service Line)			n Cemete  . Name and Addre			agerstown,	MD neral Home	
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ľ	ă.		23a. Part1. Enter the disease, or compshook, or heart failure. List only	plications that caused the de-						Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Coronary A	rtery D	isease				Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a conse	,						
d		Jer	Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury	b. Hypertensi Due to (or as a conse							
,	icate be executed physician and s the burial-transit	Examiner	resulting in death) Last  Due to (or as a consequence of):								
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.O. DOX	the death c y the attenc sched for us	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 🗆	Ectopic pregnancy Other (specify)	/		very Day Year		
cords, r	uires that signed t Id be det	by	Part II. Other significant conditions on $DJD$	ontributing to death but not re	esulting in the ur	nderlying cause giv	en in Part I.		cco use contribute to	the cause of death?	
l Deco	ding Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Completed						24a. Was an autopsy performe 1  Yes 2  □	prior to c	topsy findings available completion of cause of	
VICA	Physician: r this certifica ral director, i	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death				
5	y Physer this eral di	7: To	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	t 3 DOA 0 O O O O O O O O O O O O O O O O O O	4 A Nursing Hor	me 5 Residence 28d. Describe how	ce 6 Other (Spec	eify)	
2	arth. arth. rr; Affe	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		k? Yes 2 □ No				
	al or Atte s after de al Directo ed in by ti	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At building, etc. (Spec	home, farm, stre cify)	eet, factory, office	2	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral Director.	edical (	29a. Certifier 1 🔀 Certifying Ph (Check only one)	ysician: To the best of my kr niner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the tir restigation, in my o	me, date and place, a opinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)	
	Som this	Me	29b. Signature and title of certifier	de MD.		29c. Licens		29d	I. Date signed (Month		
0	X		,	עיי.		D006	6116		7/14/2008	<b>;</b>	
	1		30. Name and address of person who can Andeleeb Ali, M.				own Mn 21	740			
ß	Sta Registr		31. Date filed (Month, Day, Year)  JUL 1 4 20	32 Delietrarie Sign		4	7WII 9 EHD 4.1	L / TU			

State Registrar 30. Name

31. Date filed (Mo

Hagerstown

completed cause of death (Item 23a) (Type, Print)

npus Rd.

D0056783

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 23954 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Titelman Joseph /Medical July 4, 2008 1700 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 54 vre 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1**X** M 2□ F Director 216-62-6914 2/19/1954 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show a or 28a-f show 1 XYes 2 □ No Directo Maryland Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 9715 Healthway Drive 21811 th and Mental Hygiene. 27 is marked other than "natural", or items 23a traumatic event, the Medical Examinal it ust be USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ş white 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 truck driver trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Titelman ပ Teresa Coulter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tra Mary Titelman/wife 9715 Healthway Dr., Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 7/7/08 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licenses Sino ( Chompson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Rena /Medical Due to (or es e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 XNo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🖺 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred SS 4 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Doo 64120 714/08 30. Name and address of purson who completed cause of death (Item 23a) (Type, Print) ACH 9733 Howth way drive Berlin MD

Syl

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45-11-2

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2008

Zeeshan

			For State	State of Ma	aryland		artment of F			tal Hyg	iene	ากล	2395
ų.	5.14	-	Registrar     Decedent's Name (First, Middle, Last)		. (			Deali	2. [	Date of Deat	h		3. Time of Death
4	Physici /Medic		DOROTHY	G	VAC	ENT	TINE			Onth 7	Day	Year 8	2300
	Examin	er	4a. Facility Name (If not institution, give s	street and number)			4b. City, Town, o		of Death		4c. Count		_1
	Funeral	7	1619 Ruxton Road 5. Social Security Number 6. Sex	7. Ag	e (In yrs. la	ast birthday)	Edgewate If Under 1 Year		r 24 Hrs. 8. [	Date of Birth	-l	Arunde	ace (State or Foreign
1 - C	Funeral Director		405-60-0810	M 25€ 61	, ,	Yrs.	Months Days	Hours	Min. 12	Month, Day, /13/19	Year) <b>46</b>	Count	Virginia
	pug »		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation					10	Od. Inside City Limits
	Maryli f sho	ō	Maryland Anne Aru	lahr		water							1 ∐Yes 2 No
	r 28a-	Directo	10e. Street and Number	Idei	Dage	Water	10f. Zip Code			10	og. Citizen of	What Count	try?
	tth wit 23a o ust be		1619 Ruxton Road				21037				USA		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11, Waltar Oldius	12. Was Decedent Armed Forces?		3. 13.	Was Decedent of H If Yes, specify Cub	lispanic O an, Mexica	rlgin? (Specify an, Puerto Rica	Yes or No- n, etc.)		ce - America ick, White, e	
36	urs aft al", or xami	þ	1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ ! If Yes, Give Λ Year or Dates:	NO		1 □ Yes 2 ∏ No	Specify	<i>/</i> :		Speci	<sup>∱y:</sup> White	e
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g 2	filed v Hygie other 1	Be Completed	12 17. Father's Name ( <i>First, Middle, Last</i> )			OJ. I.	ice manag		ner's Name (Fir		Boatin Maiden Surna		
<u>lan</u>	uld be Mental rked ( tic ev	To B	A.K. Grizzel					Luci	ille	Willi	amson		
Baltimore, Maryland 21215-0036	2 sholl and N is ma		19a. Informant's Name/Relationship (Ty	•		I	ng Address (Street						Code)
ა ე	1 and 1 Health em 27		Peter Valentine/Hu	ısband	20h Pla		Ruxton R	oad I	dgewat:		2103 20c. Location		wn State
nor	Pages nent of f int: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 🔊 ☐ Other (Specify)	iemoval from State	ce	metery, crei	matory or other pla	i				-	
alti.	permit. Pag Department Important: I any injury o		21. Signature of Juneral Service License	be <sub>f</sub>	п1	Licres	st Cemete 2. Name and Addre	ry ; ess of Faci	7/9/200	98   P. K	<u>annapo</u> alas F	unera.	Maryland 1 Home
ñ	Deg any		In 8. Kal	12 4			73 Solom						
			23a. Paz. Enter the disease, /r complished, or heart failure. st only or	cation hat caused ne cause on each li	d the death, ne.	. Do not ent	er the mode of dyir	ng, such a	s cardiac or res	spiratory arre	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	10	wal	Cel	llca						4 MONTHS
	Examiner			Due to (or as	a consequ	ence of):							
30 <u>0</u>	O CONTRACT	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as	a conseque	ence of):							
	scuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last										
8760,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as	a consequ	ence of):							
687	ficate physisthe	edical		1									
Box	death certifica e attending ph ed for use as t	Physician/Me	23b. was decedent pregnant	3c. If yes, outcome 1 ☐Live birth			Ectopic pregnanc	u,			23d. D	ate of delive	ry
	0 0 0	sicia	in the past 12 months?	4☐Pregnant at			Other (specify)	у			M	onth	Day Year
о. О	The law requires that the de te has been signed by the a wage 2 should be detached t	Phy	9 Unknown  Part II. Other significant conditions con	ntributing to death b	ut not resul	Iting in the u	nderlying cause giv	en in Part	1	23e. Did tob	acco use cor	ntribute to th	e cause of death?
Records,	uires t signe id be o	d by	artin outsi organisani oonahono oo	Tablang to obtain b	at not too	iang in are a	ndonymg dadoo g			1 □ Y∈		3 ☐ Proba	_
Š	tw require been signal	lete								24a. Was a	n 24b.	. Were autor	osy findings available
	sician: The law certificate has l irector, page 2 s	Completed								autops perforr 1 Yes 2	y ned? ⊇☑No	death?	npletion of cause of 2 □ No
Vital	clan: ertifica ector, p	Be C	25. Was case referred to medical examiner?				1-	22 8 BW	ce of Death (Ci				
	Physic this c	은	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie		R/Outpatier	IL OLI DOX		lursing Home	/	nce 6 🗆 Ot		1)
Division or	ding F. h. After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da		Injury	Wor	rk? ∣Yes 2.[		Describe no	w injury occu	rreu	
VISI	l or Attend after death Director: ,	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of inj	ury - At hor	me, farm, str	reet, factory, office			Location (St City or Towr		ber or Rural	l Route Number,
	tal or rs afte ral DIr led in	Certification:	T	building, et	ic. (opecny)	,				City or Town	, Glate)		
	To the Hospital or Attending Physician: within L24 hours after death.  To the Funeral Director: After this certification completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Physical Check only one)	ner: On the basis o	of examinati								
	o the vithin 2 o the omple	Med	29b. Signature and title of certifier	and manner sta	ated.		29c. Licens	se number		2	9d. Date şigyn	ed (Month, L	Day, Year)
	<b>⊢ ≶ ⊢</b> Ö		Prince X	de	Ar	W	0	21	438		Jule	108,	2008
			39. Name and address of person who co	ompleted gause of d	leath (Item	23a) (Type,	Print)		/1		1	0. [11	IN LIKUI
			31. Date filed (Month, Day, Year)	G FN	rar's Signat	1) 44	1 IJEFE	USE	HG HI	NAy (	TNNA	YOU, UVI	NIX
	Sta Registr		31. Date filed (Month, Day, Year) <b>JUL 0 8 2</b> 0	008 32.491811	ar a Signal	K .	liet,			,			

			State of Maryland / Department of Health and M  1- State Registrar amend #20a&b per FH G884 19/09/08 JF Death	ental Hyg R	iene eg. No 2008	23956
10	Physici	an	1. Decedent's Name (First, Middle, Last)	Date of Deat     Month	h Day Year	3. Time of Death
1	/Medic	al	Thelma Washington  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	July	10, 2008 4c. County of Deat	10:35A M
7	Examin	er	124 West Franklin Street,#902 Baltimore		4c. County of Deat	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign untry)
	Director		414-98-3360 70 Yrs.	Tarch16	,1938 Mis	sissippi
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary a-f sh ified a	tor	Maryland Baltimore			1 X Yes 2 □ No
	ith the	Director	10e. Street and Number 10f. Zip Code		0g. Citizen of What Co	untry?
	s 23a	ral	124 West Franklin Street, #902 21201		J.S.A.	vicen Indian
	ter de Item	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Vever Married 2 □ Married  1 □ Yes 2 ☒ No	Rican, etc.)	14. Race - Ame Black, White	
99	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify: Bl	ack
21215-0036	72 hc "natu diesi	Completed by	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	ng	16b. Kind of Business/	Industry
12	within ene. than he Me	dmc	Elementary/Secondary (0-12)  College (1-4or 5+)  Homemaker		Own Home	
<u>d</u> 2	il Hygi other ent, t	Be Co	17. Father's Name ( <i>First, Middle, Last</i> )  18. Mother's Name	(First, Middle, N		T
Maryland	ould be Menta arked atic ev	To E	George Robinson Willie	Rocket	t	
Jar	2 sho n and rsma rauma		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rura			
e,	1 and Healtl em 27		Kenneth J. Washington/Son 4323Joycelyn Drive,  20a. Method of Disposition  20b. Place of Disposition (Name of Memory) 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120 management of Memory 120	New Or	1eans LOU	Ilslana/UI3 Town State
μ	ages ent of it; If It		1 No Burnal 2 XX emation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) New Park Cemetery 7 21	00	emphis,Te	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee  22. Name and Address of FacilityMar	1,1		
<u>~</u>	Pe III III		muchael P. Margullo 6009Harford Road			
ī,			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.	r respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)  Arr hythia			minute
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		ner				
	ecuted and transi	Examiner	if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events resulting in death) Last			
8760,	icate be executed physician and the burial-transit		Due to (or as a consequence of):			
687	ficate g phys	edical	d			
	The law requires that the death certific are has been signed by the attending r page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of del	,
Division or Vital Records, P.O. Box	e deal he att	sicia	1 □ Yes 2 □ No 4 □ Pregnant at time of death 5 □ Other (specify)		Month	Day Year
<u>Р</u>	hat the	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	pacco use contribute to	the cause of death?
ds,	uires l 1 signe 1d be (	d by	dixbetes mellins			obably 4 Unknown
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<u> </u>	ysician: The lavis certificate has director, page 2	Jom J		autops perforr 1□ Yes	ned? death?	completion of cause of
Vita	ician: sertific ector,	Be	25. Was case referred to medical examiner?	(Check only on	e)	
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ō	ital or irs afte ral Di	Cer				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier  (Check only one)  1	and due to the c ed at the time,-d	ause(s) and manner as late and place, and due	s stated. e to the cause(s)
	ro the	Mec	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (Mont	h, Day, Year)
	P.M		MA Saligno MD N52113		July 17	7008
ł	W		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ru(Arr) Shu-2sys, 30 (St Marl Bell	en us	21202	
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature			
	Registr	ar	IIII 2 4 ZUUX			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 23957 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 12:53 P M Myrtle Mae Wilson July 14 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City
If Under 1 Year | If Under 24 Hrs 3521 Angus Valley Trail Howard Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 08/23/1908 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🗓 F 99 212-05-8995 Director Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Marical Examine: must be notified at 10a. State 1 ☐ Yes 2 X No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3521 Angus Valley Trail 21042 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ∐Yes 2**XX**No Specify: Specify: White <u>ĕ</u> 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Roofing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Dresher ဂ Margaret Boyce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey Albaugh / Daughter 6389 Nika Ct. Port Orange, FL. 32128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State 07/18/2008 | Great Mills, Maryland 4 ☐Donation 5 ☐ Other (Specify) <u>Holy Face Cemetery</u> 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee M01206 Kyle S. Simons 22955 Hollywood Road Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Years disease or condition resulting in death) Dementia /Medical Due to (or as a consequence of): Examiner Hypertension Years Sequentially list conditions, if any, leading to immediate cause in the uncertain a Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. if yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy ę Month Day 5 Other (specify) P.0. the 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate | 2 □ No 1 ∐ Yes 2 XX No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending **XX**Natural 5 Pending the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and tive of certifier 29d. Date signed (Month, Day, Year) 29c. License number D42998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cheryl Leonardi 4801 Dorsey Hall Drive Suite 205, Ellicott City Maryland 21042 Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 7 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 Year July **Physician** Michael Thomas Wells 7 3:42 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1003 Scarlet Oak Court, Apt. 1-A Carroll Hampstead If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Date of Birth (Month, Day, **Funeral** Days Hours 1X M 2□ F 49 Yrs. Maryland 1958 Director 213-68-9954 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Directo Maryland Carroll Hampstead 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 and injury or other traumatic event, the Medical Experiments 200 or 2000. 1003 Scarlet Oak Court, Apt. 1-A 21074 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 197 If Yes, Give Year or Dates: 198 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1977-1 □ Never Married 2 □ Married Specify: white 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 X Divorced 1981 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Parts Specialist Machine Repair 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles L. Wells Emma Branchetti ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5526 Oakmont Avenue Bethesda, Maryland 20817 Charles J. Wells - Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 9, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Cremation Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Eline Funeral Home M01072 934 South Main Street Hampstead, Maryland 21074 / www 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SCV **Physician** ear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 → Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier WJL 4+114 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marchester Rl Marchester M lerson Jr. MD 2973 P. Hen Herbert 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 10 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 23959 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician July 20්රී්ව් 6:34 P Betty Louise Winn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day, Year)
April 25,1933 Pennsylvania 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1 □ M 2 □ ¥ Months Days Hours 199-24-7788 75 Director April Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I've Medical Exprinter must be partified at once. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1. Yes 2 □ No Director Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 Georgetown Road 21793 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify <u>۾</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luther A. Curran Margaret Trimmer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard A. Winn / Husband 30 Georgetown Rd., Walkersville, MD 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Memorial 7/11/2008 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Funeral Home 21. Signatule of Funeral Service Licensee 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 Approximate Interval Between Onset and Death 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final **Physician** mo disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the chiping Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical as the attending for use as If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) □Yes sate has been signed by the page 2 should be detached 9 Unknown 9 ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ∐Yes 2 No within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ၉ 1 Inpatient Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) Kd, Wordshin 454 0200 31. Date filed (Month, Day, Year) State 2008 11 Registrar

			1 - For State Registrar		of Marylan	d / Depa	artment	of H	ealth a		ental Hyd	iene		
	104 A 1	-	Registrar  1. Decedent's Name (First, Middle	la Lact)		Ce	rtificate	of L	<i>Jeath</i>		2. Date of Dea		200	8 23960 3. Time of Death
3	Physici		MARY	JEAN	WH	IETZEL					Month	10 Day	2008	
*	/Medio		4a. Facility Name (If not institutio				4b. City, T	own, or	Location o	of Death	OOLI		County of Dea	
		<b>13</b> /	MONTGOMERY GEN				OLNI						MONTGO	
	Funeral Director		5. Social Security Number 217–34–0377	6. Sex 1	7. Age (In yrs. 69	<i>last birthday)</i> Yrs.	If Under 1 Months	Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day	, Year)		irthplace (State or Foreign Country)
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	arylar show	-	10a. State 10b. County		10c. Cit	y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 🛣 No
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	h with	a D	24222 Hipsley	Mill Road			1011 2.19		2088	2			ited S	•
	r deat	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13.	Was Decede If Yes, specif	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	1	4. Race - Am Black, Wh	nerican Indian,
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2	ithin 7 ne. nan "n	Completed	Elementary/Secondary (0-12)	st grade completed) College (	1-4or 5+)		kind of work DO NOT use		uring most	t ot workii	ng			
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Maryland 21215-0036	2 should and Men Is marke aumatic		19a. Informant's Name/Relations								I Route Numbe			
	ss 1 and 2 should of Health and Men item 27 Is marke other traumatic		Robert L. Whet	zel / Hus							d, Gait			Md. 20882
Baltimore,	Pages nent of h ant: If ite ary or of		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (5		State	lace of Dispo					4/08			or Town, State  Maryland
alti	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service		Mt	. Tabo	2. Name and	Addres	s of Facility	v			•	Maryrand
m —	an)	r di	murie	4.13	arke	-	P. O.	Вс	x 50	38,	Funeral Laytons	vill	e e, Md.	20882
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that of only one cause on o	caused the deatl each line.	n. Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory arı	est,		Approximate Interval Between Onset and Death
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Rox	death certifica e attending ph d for use as th	lan/	23b. Was decedent pregnant in the past 12 months?	1 □ Live	tcom <i>e</i> pf pregna birth 2 □ Feta	Ideath 3	Ectopic pre					23	3d. Date of de	elivery Day Year
o.	000	Physician/Med	1 □ Yes 2 🗷 No 9 □ Unknown	4⊟Pregi 9⊟Unkn	nant at time of d own	eath 5L	Other (spe	city)						,
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ord	w requires been sign should be	ted						-	_		1 🗆 Y	<i>e</i> s 2	No 3∏ F	Probably 4 Munknown
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,	0		30. Name and address of person	who completed caus	se of death (Item	23a) (Type,	Print)							
	10	1	Alok Mathur,	204	000 Olne	A		.11e	Road	, 01:	ney, Md	. 2	08 <b>3</b> 2	
	Sta Registra		31. Date filed (Month, Day, Year)	2008	Registrar's Signa	k do	whe							
165				100										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Jeannette M. Wilkinson July 08. 2008 7:41 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Clinton 0 Prince George's 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Months Days Hours Min. 115-14-6721 Director 83 Sept.1, 1924 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. It filem 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Prince George's Brandywine 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 8705 Timothy Road 20613 United States of Ameri¢a Funeral "natural", or Items dical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give WWII Year or Dates: WWII 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3√ Widowed 4 Divorced White er than "natur, the Medical F Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Cafe<u>teria Manager</u> P.G. County Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ John Sculley ၉ Marion Leone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Wilkinson/ Son 8507 Cedarville Road, Brandywine, MD 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State = ₽ Department or Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery July 17, 2008 Cheltenham, MD 22. Name and Address of Facility Huntt Funeral Home, Inc. 3035 Old Washington Rd., Waldorf, MD 20601 M01436 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician morthous disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ a 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed thrombour 1 ☐ Yes 2 ☐ No 2 Hospital or Attending Physician: 25. Was case referred to medica examiner? funeral director, Be 26. Place of Death (Check only one) 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ NO 1 Inpatient မှ After this 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 29a. Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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B#gistrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

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Clinton M

			1- For State of Maryland / Registrar	Depa Ce	artment of Health and rtificate of Death	Mental Hygie	ene 2008	23962	
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1	Exami	ner	4a. Facility Name (If not institution, give street and number)  UNION HOSPITAL  5. Social Security Number 6. Sex 7. Age (In vrs. last by	L'-41 L 1	4b. City, Town, or Location of Deat  ELKTON  If Under 1 Year   If Under 24 Hrs		4c. County of Death		
	Funeral Director		5. Social Security Number   6. Sex   7. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In yrs. last be considered   1. Age (In	Yrs.	If Under 1 Year   If Under 24 Hrs  Months   Days   Hours   Min.	(Month, Day, Y	yea <i>r)</i> 9. Birth Cour 923 DE	place (State or Foreign ntry)	
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9036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	d by Fund	11. Marital Status  1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Marr		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2[X]No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: WH	etc.	
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	1 and 2 shou Health and M em 27 is mai		CYNTHIA WHITE - DAUGHTER 1	226	MASHINGTON STREE	T, WILMING		9801	
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other to orce.		1 Rurial 2 Comption 2 Demount from State   Cemet	HEDF 22	2. Name and Address of Facility	Y 15, 08 WI	LMINGTON,	DE 19805	
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2	+   VA	8	20 Name and address of person who completed cause of death (Item 23a)	(Type, F	St. Su. to 30	ElKton	MD 21	921	
£	Sta Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature	bore	V			-	

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2008 JULY ANDERSON WILLIAM WATERS 6. 0025 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital MONTGOMERY Silver Spring 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan, 3, 9. Birthplace (State or Foreign Hours 1 🕅 M 2 🗆 F Months Days Virginia 92 Ĩ916 214-01-9722 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13603 Parkland Drive 20853 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ⚠ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Delivery Driver Electronics Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry G. Waters Minnie W. Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda W. Branch (Daughter) 755 Chapelgate Dr, Odenton, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD incoln Park Cem 7/11/08 21. Signature of Funeral Servi 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) stage Due to (or as a conse wince of): Hypertermon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due curbr as a consequence of). Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and the burial-tran Division of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical as has s after death.

I Director: A
od in by the fu within 24 hours a

To the Funeral C

completely filled filled

**Physician** /Medical

Physician

/Medical

Director

by Funeral

Completed

Be

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Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Ilmportant: if item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examinar must be preferance.

Baltimore, Maryland 21215-0036

in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4 Pregnant at time of death 5 Other (specify)	Month Day Year		
Part II. Other significant conditions  Herria tosia	, , , , , , , , , , , , , , , , , , , ,	olid tobacco use contribute to the cause of death?		
	a	Vas an utopsy findings available prior to completion of cause of death? as 2₽No 1 □ Yes 2 □ No		
25. Was case referred to medical examiner?	26. Place of Death (Check on	nly one)		
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 R	Residence 6 ☐ Other (Specify)		
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	on (Month, Day, Year) Injury Work?  M 1 Yes 2 No	ibe how injury occurred		
3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined	286. Place of Injury - At nome, farm, street, factory, office 28f. Locatio	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my knowledge, death occurred at the time, date and place, and due to uniner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated.	the cause(s) and manner as stated. me, date and place, and due to the cause(s)		

29c. License number

D0064100

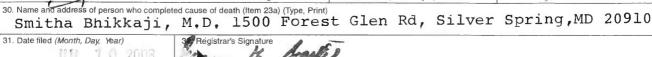
29d. Date signed (Month, Day, Year)

July 6, 2008

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



M.D.

Amend #10b, per FD, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. CCHD, Anne Arundel, State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 7/10/08, drw 23964 2. Date of Death 1. Decedent's Name (First, Middle, Last) 07/03/2008 Year Physician 11:41 p<sup>M</sup> Patricia Ann Windsor /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign
Country) **Funeral** Days Hours Months 01/10/1958 Washington, DC 50 Director 217-76-5452 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at ¹%Anne Arundel 1 □Yes 2X No Director Dunkirk MD -Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20754 U.S.A. 6310 Oaklyn Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, 1 ∐Yes 2 If Yes. Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: White \$ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joan Elizabeth Wentzel George Benton Hibbs ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6310 Oaklyn Court, Dunkirk, MD 20754 Ron Windsor/Husband 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/11/2008 Cheltenham, MD MD Veterans Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatus Funeral Service 22. Name and Address of FacilityLee Funeral Home Calvert, P.A. Lisa M. Lounts 8125 Southern MD Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) gram negative /Medical ue to (or as a consequence of) Examiner munocompromis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Fulminent hepatic attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760. Physician/Medical toimmune 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) signed by the a o 9 Unknown 9 Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' 1 □ Yes 2 -N 1 □ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 → No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P after death. I Director: After d in by the funera Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 □ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after

To the Funeral Direct

completely filled in by Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only and manner stated. 29b. Signature and Ale of certifier 29d. Date signed (Month, Day, Year) D585(0 mg 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Olexo

State

Registrar

31. Date filed (Month, Day,

Yea

32. Registra Signature

2008

State of Marylan

nd / Department of Health and Mental Hygien $2008$	2396	5
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		•	1 - State Registrer		Ce	rtificate of	Death		Reg. N	lo.	50	200	50
			1. Decedent's Name (First, Middle, Las					2. Date of D	eath		Year	3. Time of D	eath
	Physici /Medic		Pauline Marie	Wexler				July	7, 2	2008		1308	М
	Examin	1,000	4a. Facility Name (If not institution, give Calvert Memorial				Frederick	:	4	calv			
5 × 5	Funeral Director		5. Social Security Number 283–14–3727 6. Security Number 11	x 7. Age 7. Age 87.	(In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of 8 (Month, 1) 06-07	irth Pay Yea -192	1	9. Birthp Cour Ohic	place (State or I ntry)	-oreign
	pug *		Usual Residence of Decedent  10a, State 10b. County		10c. City, Town or L	ocation					1	0d. Inside City	Limits
	a-f eho	ctor	MD Calvert		Lusby							1 □ Yes 2	
	h with the	al Director	10e. Street and Number 12199 Bonanza Tra	ail		10f. Zip Code 20657			1	10g. Citizen of What Country? United States			
036	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or items 23s or 28s-f show event, Its Medical Examinations as a political standard.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 W Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cub	ecify Yes or N Rican, etc.)	Black, White					
5-0	72 h	Completed	15. Decedent's Ed (Specify only highest grad		(Give	edent's Usual Occup e kind of work done	during most of work	ing	16b.	Kind of Bu	usiness/In	dustry	
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0 0	filed Hygi other	Be Cc	17. Father's Name (First, Middle, Last)		Tious	CWIIC	18. Mother's Name	e (First, Middi					
ılan	uld be Aental rked tic ev	To B	Henry L. Ebbesko	tte			Martha K	ershne	r				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other treumatic event, it a Medical Examinar must be notified as once.		19a. Informant's Name/Relationship (7 Ronald G. Wexler				and Number or Rural Trail, I						
nore,			20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		20b. Place of Disp cemetery, cre Gate of H	20c. Location - City or Town, State /2008 Silver Spring, M							
Baltir	permit. P Departme Importan eny injur		21. Signature of Funeral Service Licen			22. Name and Addre		ausch	Fune	eral	Home	, P.A.	
90	TITLE		23a. Part1. Enter the disease, or comp	lications that caused t	the death. Do not er							Approximate	
وش	Physician		shock, or heart failure. List only of Immediate Cause (Final	one cause on each line	dincon	in Sh	och					Oriset and De	
	/Medical		disease or condition resulting in death)	a. Due to Jer as a	consequence of):			,	4	,		1 au	4
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	pe is	luei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):	12 178 /	KLACLI	etron 1 van Discos 5			SUK		
•	icate be executed physicien and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):	10100	usuu		Dis	w	09.3	,	
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	ertificate ling phy e as the	Medical		-									
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Petal death 3	□Ectopic pregnanc □ Other (specify) _				te of delive	ery Day Ye	ar	
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ğ	w require been sig should b							1	] Yes	2 No	3 ☐ Prot	oably 4 □Un	known
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ita	iclen: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				26. Place of Deat		_				
<u>5</u>	Physic this co	ို	1 ☐ Yes 2 No	Hospital:		III JUDA	ner: 4 Nursing Ho					fy)	
uc	ding F h. After funera	tion:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time (	Wo	ryat rk? ]Yes 2 □No	28d. Describe	e now in	jury occur	red		
isi	or Attendate death Director:	ficat	2 Accident investigation 3 Suicide 6 Could not be		ry - At home, farm, s		1 102 5 1140	28f. Location	Bf. Location (Street and Number or Rural Route Number,				
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	To the Hospitel or Attending Physiclen: The within 24 hours after death.  To the Funerel Director: After this certificate hi completely filled in by the funeral director, page	edicai (	29a. Certifier 1 Certifying Phyone) 2 Medical Exem	ysician: To the best of iner: On the basis of and manner stat	examination and/or in	ith occurred at the ti nvestigation, in my	me, date and place, opinion, death occur	and due to th	e cause e, date a	(s) and ma and place,	anner as s and due t	stated. o the cause(s)	
	To th within To th comp	Me	29b. Signature and the of genting	1.		29c. Licen	se number		29d. [	te signe	d (Month,	Day, Year)	~
			* 1811VIIII	Mo		D4	6419		/	july	1 1,	7000	)
	17		30. Name and address of person who charlene A Lei	completed cause of de	ath (Item 23a) (Type	Print) 4 (har	se number 6419 les St L	a Pla	Ja,	MI	2	0646	
	Sta	te	31. Date filed (Month, Day, Year)		r's Signature								
	Registr	ar	JUL 8 2008	Blocker.	15. Ana	de l'							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 = For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day June 30, 2008 8:06 P M Charles Francis 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Calvert St. Leonard 1181 Thompson Court If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 € M 2 🗆 F 89 Apr 18, 1919 Pennsylvania 578-03-7596 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☑ No Calvert St. Leonard MD 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number 20685 1181 Thompson Court 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 ▼ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NASA - Federal Gov't Physicist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gibson Grace Henry James Yost 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1181 Thompson Court St. Leonard, MD <u>Margaret Yost (wife)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July Pati. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gift Registry 2008 Hanover, Maryland 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Fy 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA 2 WEEKS disease or condition resulting in death) Due to (or as a consequence of): ten weeks ASPIRATION SILENT Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): month CVA Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HTW 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural

/Medical Examiner 68760 ئم Records, Division or Vital After t

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

Director

Be Completed by Funeral

death with the Maryland

filed within 72 hours after

Pages 1 and 2 should be

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Department of Important: If it any injury or o

Physician

Examiner

Completed by Physician/Medical

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Certification: To

2 Accident

3 Suicide

4 ☐ Homicide

(Check only

6 ☐ Could not be determined

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other traumatic

Maryland

as use page 2 funeral or Attending within 24 hours after death To the Funeral Director: filled in by completely

ARW

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

SCARIA MATHEW MD 2008▶

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registras Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

LUSBY MD 20657 , POBUX 1789,

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D36969

28f. Location (Street and Number or Rural Route Number, City or Town, State)

7/1108

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Mary	yland /	Depa Cer	rtment of F	lealth a	and Mer	ntal Hyg	giene Reg. No. 2 (	308	23967	
32	Physici /Medic		1. Decedent's Name (First, Middle, WOLTTER - (	G. Zege	r					Date of Dea Month	Day /	Year 08	3. Time of Death  4:079 M	
	Examir Funeral Director	er	Social Security Number 6	ing Cent	er In yrs. last 82	birthday) Yrs.	4b. City, Town, of Hager Hand Grant Hand Grant Hand Hand Hand Hand Hand Hand Hand Hand	sto	24 Hrs. 8. Min.	Date of Birth (Month, Day n. 22	, Year)	9. Birth	ngton  place (State or Foreign  intry)	
10	TO		168-24-4879         Usual Residence of Decedent         10a. State       10b. County	11	Oc. City, To	own or Lo	cation		Įа	n. 22	, 1920		10d. Inside City Limits	
	the Mary	Director	PA Frankl  10e. Street and Number	in	G	reen	castle				10g. Citizen o	of What Cou	1 □Yes 2 No untry?	
	3a oi	<u> </u>	14267 Mercersbu	rg Road			1	7225			1	USA		
36	s after death ", or Items 2 aminer mus	by Funeral	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces?	er in U.S.		Vas Decedent of H f Yes, specify Cub	Hispanic Ori an, Mexicar		Yes or No- an, etc.)		Race - Ameri Black, White		
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)			(Give life. L	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  ngine repairman					16b. Kind of Business/Industry  Truck		
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Maryland	should be fill and Mental H s marked oth umatic even	To Be	17. Father's Name (First, Middle, Last)						er's Name <i>(Fi</i> Mary	E. Tri				
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e,	is 1 and 2 of Health a item 27 is other trau		Mary L. Zeger/wi				Mercers		Road,	Green	castle 20c. Locatio			
Jor.	Pages 1 ar nent of Hea ant: If item 3 ury or other		1 Burial 2 □Cremation 3	Linemoval from State			sition (Name of natory or other pla	, ,	July 1	7,	Merce			
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Ba	permit. Page Department of Important: If any Injury or once.		Allen T	· Fries		79	47 N. Pa	rk Ave	e., Me	rcersl	ourg,			
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	uted d ansit	Examiner	Sequentially list conditions, if any, reading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events		typ	pol	you	dis	$\sim$					
8760,	ate be executed obligation and the burial-transit	lical Exa												
Box 6	ath certific ittending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf p 1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim 9 ☐ Unknown	☐ Fetal de	ath 3	Ectopic pregnanc Other (specify)	y				Date of deli	very Day Year	
rds, P.O.	quires that the de n signed by the a uld be detached t	þ	Constant of the significant containing to death but not recoming in the discovering scale given in a dis-						l.	23e. Did tobacco use contribute to the cause of death 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unkr				
Division or Vital Records,	The law requir ate has been si bage 2 should l	Completed							- [	24a. Was autop perfo		b. Were aut prior to c death? 1 ☐ Yes	topsy findings available completion of cause of	
ita	ı <b>lcian:</b> Th certificate ector, pag	Be C	25. Was case referred to medical examiner?					26. Place	e of Death (C		/-			
<u>&gt;</u>	ulng Physician: The	ဥ	1 ☐ Yes 2 📉 No	Hospital:			t 3 DOA				tence 6 □		cify)	
n C	ding F	ü	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	'ear) 28	lb. Time of Injury	Wo			. Describe h	now injury occ	curred		
ivisio	or Attend frer death Director: in by the i	Certification:	2 Accident investigat 3 Suicide 6 Could no 4 Homicide determine	t be   280 Place of injuny		, farm, str		Yes 2□		Location (S City or Tou		mber or Ru	ral Route Number,	
	To the Hospital or Attent within 24 hours after death to the Funeral Director: completely filled in by the	Medical Ce		Physician: To the best of raminer: On the basis of examiner and manner stated	kamination									
	To the vithin 3	Mec	29b. Signature and title of certifier				29c, Licens	se number			29d. Date sig	ned (Monti	h, Day, Year)	
٠,	150		-(	In M.D.			Do	0666	516		٦	1141	08.	
-	13		30. Name and address of person with Andaleeb A		th (Item 23	Ba) (Type,	Print)	ager	rstvu	וחט	MD	217	10	
ì	Sta Registi		31. Date filed (Month, Day, Year)	00.00	01		bout							

Isabelle Alexander-itethnan

			1 - State of Registrar	Marylan	d / Depa <i>Cer</i>	artment of H <i>rtificate of I</i>	lealth and I Death	Mental Hy	giene A	2008	23968
			Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
	Physici /Medic		ISABELLE ALEXANDER					Month 7	15 Day	Z008	12:50 P M
-	Examin		4a. Facility Name (If not institution, give street and num			4b. City, Town, or	Location of Deatl	า	4c. C	ounty of Deal	th
-soil t			5. Social Security Number 16. Sex XX			Baltima If Under 1 Year	orc, MD If Under 24 Hrs.	8. Date of Bir	th	l o Rie	thplace (State or Foreign
	Funeral Director		5. Social Security/Number J 6. Sex XX 1 M 2 F	7. Age (In yrs. l	Yrs.	Months Days	Hours Min.	JULY 11	ay, Year)	9. Bill	ountry)  MD
	D		Usual Residence of Decedent								
	arylar show	Ž	10a. State 10b. County	10c. City	, Town or Lo	cation					10d: Inside City Limits 1, Yes 2 No
	the M	Directo	MD ANNE ARUNDEL  10e. Street and Number	BR00	KLYN PA	RK 10f. Zip Code			10a Citiza	en of What Co	
	3a or		212 MIDLAND AVE.			21225	;		rog. Onize	USA	MINITY.
	be filed within 72 hours after death with the Maryland ttal Hygiene.  dother than "natural", or items 23a or 28a-f show event, the "Notical Exartiner must be notified at	Funeral	11. Marital Status 12. Was Deced	lent Ever in U.S	S. 13. V	Vas Decedent of H f Yes, specify Cuba		pecify Yes or No	)- 14	1. Race - Ame	
စ္တ	after or ite		Armed Ford  1 Never Married 2 Married 1 Yes, Give	2 No	1	Tes, specify Cuba	Specify:	o nican, etc.)		Black, White	
2-0036	hours tural",	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Da		16a Dans	lent's Usual Occup	ation			Bpecify: BL	
5	in 72 n "nai	Completed	15. Decedent's Education (Specify only highest grade completed)	4==5-2	(Give life. L	kind of work done of NOT use retired	ation during most of wor f)	king	TOD. KIR	2 Of Business/	industry
Maryland 2121	d within giene.	Com	Elementary/Secondary (0-12) College (1- never attended	40r 5+)	never	worked				× :	
p	e filed ral Hygiral A other	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle	, Maiden S	urname)	
yla	should be land Mental s marked o	2	GLYRON ALEXANDER				DARA L. A				
Nar	12 shoh and hand 7 is m		19a. Informant's Name/Relationship (Type. Print)	T. ISO	1	g Address (Street				Town, State, .	Zip Code)
	s 1 and 2 should of Health and Men Item 27 is marke other traumatic.		GLYRON ALEXANDER  20a. Method of Disposition	FATHER 20h PI	1	IDLAND AVE.	BRUUKLYN	Date		ation - City or	Town, State
nor			1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	tate C6	emetery, cren	natory or other place				IMORE, M	
altimore,	permit. Page Department of Important: If any Injury or once.		21. Signal r o Funeral Service Lice See	DATE	-	Name and Addres	·	2000	DATE!	inone, ii	
ĕ	lmp any any		KI CRECORY FINK	M0114		NK FUNERAL 5 CRAIN HWY		BURNIE, M	D 21061	1	
			23a. Part1. Enter the disease, or complications that can shock, or heart failure) List ολ ly one cause on ea	used the death	. Do not ente	er the mode of dyin	g, such as cardia	or respiratory a	ırrest,		Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	nonary							Onset and Death
-	/Medical Examiner		resulting in death)  Due to (co	ras a con Ju	ence :	oplasia Dysplas					
	LAMITICI	ē	Sequentially list conditions,	natrup	hic	Dysplas	ia				
	nsit	min	cause. Enter Underlying Cause (Disease or injury	i as a consequ	ence on.						
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98/60	ificate be executed g physician and is the burial-transit	edical	d								
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ROX	death cert e attending d for use a	ian/	23b. Was decedent pregnant in the past 12 months?	rth 2 Fetal	death 3	Ectopic pregnancy	у		23	Bd. Date of de Month	livery Day Year
_ :	w requires that the death certific been signed by the attending I should be detached for use as	Physician/M	1 ☐ Yes 2 ☑ No 4 ☐ Pregna 9 ☐ Unknown 9 ☐ Unknown	ant at time of de wn	eath 5∟	Other (specify)					
٦.	requires that the		Part II. Other significant conditions contributing to dea	ath but not resu	lting in the ur	derlying cause give	en in Part I.	23e. Did	tobacco us	e contribute to	o the cause of death?
Vital Records,	quires n sign ald be	d by	Respiratory Failure					1 🗆	Yes 2	√No 3□P	robably 4 Unknown
ပ္ပ	law red as bee 2 shou	olete	J					24a. Was		24b. Were a	utopsy findings available
Ĭ	: The is cate ha	Completed						auto perfo 1 □ Yes	psy ormed? 2 ☑ No	prior to death? 1 ☐ Yes	completion of cause of
<u> </u>	sian: ertifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Dea			, = 100	, 22.110
_	Physician: r this certific ral director, p	၉	1 Yes 2 No Hospital: 1 in	patient 2 🗆 🛭			4 □ Nursing F	lome 5 ☐ Res	idence 6	□ Other (Spε	ecify)
Ĕ	ding Physician: The lav h. After this certificate has funeral director, page 2 !	ion:	Takarar b Eli chang	f Injury , <i>Day, Year)</i>	28b. Time of Injury	28c. Injury Work		28d. Describe	how injury	occurred	
DIVISION	Vittenc death ctor: y the	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of	of Injury - At ho	me farm stre	et, factory, office	Yes 2□No	28f Location /	Street and	Number or B	ural Route Number,
2	alor / s after l Dire d in b	Certification:	4 Homicide determined building	g, etc. '(Specify	)	, , , , , , , , , , , , , , , , , , , ,		City or To	wn, State)		ara. Francis
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral		29a. Certifier (Check only (Check only 2 Medical Examiner: On the ba	pest of my know	vledge, death	occurred at the tin	ne, date and place	e, and due to the	cause(s) a	and manner a	s stated.
	the H hin 24 the F Tplete	Medical	one) and manne	er stated.	ion and/or in			Tred at the time,			
	or vit	-	29b. Signature and title of certifier			29c. License		_		signed (Moni	
	5	-	Jones and deline	of dooth /lt-	220) /T	l Do	06615 et, Bai	2	-	7/15/0	8
	1		30. Name and address of person who completed cause  Jucklyn Leung ZZ			1. Stre	et Ri	there	MI	0 71	201
	Stat	е	31 Date filed (Month Day Year) 32 Re	gistrar's Signat	ure	2	- , un	110 100	1	Equ. V	
	Registra	ar -	JUL 2 5 2008	1 FG. 1	S. Company						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7 **Physician** 2<sup>Day</sup> Archibald 2008 Jean Α. 4:40 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Glen Burnie 20 N. Meadow Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4–28–1926 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Min. Months Hours 1 M 2XX 82 Mass. 032-18-9250 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, it a Medical Examiner must be notified at MD Anne Arundel Glen Burnie 1 ☐ Yes 2XXNo Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20 N. Meadow Drive 21060 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ∑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No white Specify Specify: ۾ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Health care Nurse 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) unkn Mary Burr Curry ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn C. Archibald / spouse 20 N. Meadow Dr., Glen Burnie MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/28/2008 Crownsville, MD MD Veterans Cemetery 21. Signatura di Fuyeral Service Lyainsee 22. Name and Address of Facility Kirkley Ruddick Funeral Home PA M01364 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician eno Corcinona disease or condition resulting in death) /Medical Due to (or as a consequence of): 15 mon The Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlansit own. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Piscose 1X Yes 2 🗌 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed2 1 Yes 2 No 1 TYes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Leath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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32. Registrar's Signature

3 yos sold Drive Glea Burare us 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23970 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** July Dimphena Adriana Alford 11, 8:00pm /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 1 □ M 2 □ F Year) Hours Director Yrs. 516-52-0438 75 Feb. 13, 1933 Netherlands Usual Residence of Decedent with the Maryland 10b. County 28a-f show 10c. City, Town or Location 10d. Inside City Limits the Medical Examinar must be notified at Director MD Carrol1 1 ☐Yes 2 X No Sykesville 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? "natural", or items 23a 6113 Oak Hill Drive permit. Pages 1 and 2 should be filed within 72 hours after death very pearment of Health and Mental Hygiene.

Important: If tem 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examination and once. 21784 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ▼No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2**X** No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: White Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Charles Hendrikus deMoor Antonia Adriana Zuijdervelt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert L. Alford (Spouse) 6113 Oak Hill Drive Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 7/14/2008 Sykesville, MD 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, P.A.
P.O. Box 195 Sykesville, MD 21784 21. Signature of Funeral Service Licenses Brian alla MO0764 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dung, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsetyand Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran Due to (or as a consequence of): the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mg Day Month Year 5 ☐ Other (specify) ed by the 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to te cause of death? ģ Completed robably 1 ☐ Yes 2 ☐ No 3 4 🔲 Unknown 24a. Was an Were autopsy findings available prior to completion of ause of death? s certificate ha autopsy performe 1 ☐ Yes 1 ☐ Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home Hospital: 1 Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 27. Manual of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Mydical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con Medical 29a. Certifie (Check only one) niner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I and manner stated. 29b. Signature and title of certif 30. Name and address of GUSU

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

08-05470	
Angela Bunn	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ngela bulin	1- For State Registrar  1- For State Registrar  Registrar	g. No. 200	8 2397
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)  2. Date of Deal	h Dav Year	3. Time of Death 1610 hrs
Separate 1	4a. Facility Name (if not institution, give street and number)  Johns Hopkins Bayview Medical Center  4b. City, Town, or Location of Death Baltimore	4c. County of Death	'A
Funeral Director	or desired the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the s	th(MM/DD/YYYY) 9. Birl 25 , 1965 Foreig Col	
any .	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
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1 with the Maryland ms 23a or 28a-f she be notified at once eral Director		USA	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Menial Hygiene. 27 is marked other than "natural", or items 23a or 28a-fahematic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		White, etc.	can Indian, Black,
ours after attural" xamine:	15. Decedents Education (Specific position (Specific position)) 15.2 Decedents Liquid Decrepation (Give kind of work done	16b. Kind of Business/	ndustry
5-0036 led within 72 h Hygiene. other than "n the Medical E	Elementary/Secondary (0-12) College (1-4 or 5+)  12th Grade Maintenance Operator	Dept. of Treatmer	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica  To Be Comple	olJoe Louis Davis   Ethel Pompey	Maiden Surname)	
MD 21 d 2 should 1 lth and Mer n 27 is mar aumatic ev			
Ages 1 an nt of Hea tr. If iter tra	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Trinity Cemetery 7/23/08	20c. Location - City or Dundalk,	
Baltin permit. Pr Departmen Importan injury or			neral Home
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arr failure. List only one cause on each line.	est, shock, or heart	Approximate Interval Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Cardiac arrhythmia  Due to (or as a consequence of):		
Per	Sequentially list conditions, if any, leading to immediate  b. Myocardial fibrosis  Due to (or as a consequence of):		
insit Examiner	to I accept any object of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s		1
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Box 68760, he death certificate be expension the attending physician had for use as the burial Physician/Medic	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	23d. Date of deliver Month	y Day Year
that the deat ned by the at detached for by Phys	1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did to	obacco use contribute to	the cause of death?
ires that the signed by the detaction of the detaction of the detaction of the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the by the	Obasity 1 Ye	s 2 No 3 Pro	pably 4 V Unknown
cords aw requ has been 2 should	24a. Was autor perfo 1 ✔ Yes	prior to death?	atopsy findings available completion of cause of the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon
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of Viling Phys After this funeral di	1 V Yes 2 No 28a Date of Injury 28h Time of Injury 28c Injury at Work? 28d Describe	how injury occurred	
Division o spital or Attending hours after death. neral Director: Aft filled in by the fune Certification:	Natural 5 Pending 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (or Town, \$	Street and Number or Ro	ural Route Number, City
Division To the Hospital or Attenct within 24 hours after death To the Funeral Director: completely filled in by the ledical Certificatic			ed.
To the He within 24 To the For completel	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.		
2	29b. Signature and title of certifier  29c. License number  O.C.M.E.	29d. Date signed (Mo	nui, Day, Tedi)
$\phi$	30. Na e and addres of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		72
State Registrar	15 14 A M AAAA AAAA AAAAA AAAAAAAAAAAAAAAA		

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			State of Maryland / Department of Health  1- State Registrar  State of Maryland / Department of Health  Certificate of Death			ene g. No.2008	23972
,			Decedent's Name (First, Middle, Last)	2.	Date of Death	n	3. Time of Death
n	Physici /Medic		Anna Rae Brodbeck		Month July	Day Year 2008	5:35p M
1	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location			4c. County of Death	
			2101 Brodbeck Rd. Hampstea			Carroll	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year Months Days Hours	er 24 Hrs. 8. Min.	Date of Birth (Month, Day,	Year) 9. Birth	pplace (State or Foreign intry) ryland
-	Director		218-32-5941 /4	Jι	(Month, Day, 11 y 3	,1934 Ma	ryland
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Mary f sho	to	Maryland Carroll Hampstead				1 ∐Yes 2 <b>X</b> Xo
	r 28a	Director	10e. Street and Number 10f. Zip Code		10	ng. Citizen of What Cou	untry?
	h with		2101 Brodbeck Rd. 210	74		U.S.A.	
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica	Origin? (Specify	Yes or No-	14. Race - Amer Black, White	
9	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	/ Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes, 2 ☑ No Specify		ari, cio.,	Specify: Wh	
8	hours ural";	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:				
5	n 72 ' <b>"nat</b> edica	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during mo life. DO NOT use retired)	ost of working		I6b. Kind of Business/l	naustry
12	withi iene. than the M	mc	Elementary/Secondary (0-12) College (1-4or 5+) Cashier			Retail	
D	illed I Hyg other	BeC		ther's Name <i>(Fi</i>	irst, Middle, M	faiden Surname)	
lan	ald be denta rked rlc ev	To B	Elisha Joshua Grothe	Emma	Stege	r	
Maryland 21215-0036	I 2 should be f h and Mental I 7 Is marked of raumatic eve		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number)				
Σ	and 2 eaith n 27 I		John W. Brodbeck, Jrson 3399 Ralph Dell			tead, MD.	. 21074
ore	jes 1 of He or oth		20a. Method of Disposition 1√2 Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place) J U 1	1y 25	2008 2	20c. Location - City or 1	Town, State
Ē	. Pag tment tant: jury o		4Donation 5DOther (Specify) Greenmount Church:	Cem.		Greenmou	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facil	Dr. N	ardt E Manche	Funeral C ester, MD	hapel P.A. . 21102
			23a. Part1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.	as cardiac or re	spiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition				Oriset in Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
	- All	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
7	ted nsit	nine	Cause (Disease or injury				
V	execu n and al-tra	Examiner	that initiated events c.  resulting in death) Last  Due to (or as a consequence of):				
68760	ificate be executed g physician and as the burial-transit	edical	d				
_		ledi					
Box	death certifi e attending   d for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Date of deli	
O.E	0 0 0	sici	in the past 12 months?  1			Month	Day Year
<u>Ч</u>	ires that the de signed by the a be detached	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part		23a Did tob	acco use contribute to	the cause of death?
Vital Records,	requires that the een signed by th nould be detache	by	Take the distribution of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control		1 ☐ Yes		,
Š	w requir been si should I	etec					
Ř	has has	Completed			24a. Was an autopsy perform	prior to c	topsy findings available ompletion of cause of
g	ician: Th certificate ector, pag		25. Was case referred to medical 26 Place		1□ Yes 2	! ☑No 1 ☐ Yes	211 No
	ysician: is certific director,	o Be	examiner? Hospital: Other:	ce of Death (Ci		nce 6 □Other (Spec	
ō	g Physer this eral di	<u>ان</u> ل	27. Manuar of Death 28a. Date of Injury 28b. Time of 28c. Injury at			w injury occurred	
0	tending Fleath. tor: After the funer	atio	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 □	□No			
DIVISION	l or Atter after dea Director	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (Str. City or Town,	eet and Number or Ru , State)	ral Route Number,
	ital o						
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date a (Checkbrily one) 1 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead of the control of the basis of examination and/or investigation, in my opinion, dead of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of t	and place, and leath occurred a	due to the ca at the time, da	luse(s) and manner as ate and place, and due	stated. to the cause(s)
	o the ithin 2 o the omple	Med	and manner stated.  29b. Signature and title of certifier  29c. Ficense namber		29	d. Date signed (Month	n, Day, Year)
)	⊢≯Fŏ		MALLO KILLS MY 11/22	3	MI	7/24/11	9
	10	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1	,,2,,00	
			Flavio Kriter MD 555, South Center Str	rect U	USIM	inster, 1	1121157
	Sta	-	31. Date filed (Month, Day, Year)  32. Registrar's Signature				
	Registra	ar	JUL 2 5 2008 Blown & Jones				

29a. Certifier

Director

Funeral

Completed by

Be

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Physician

/Medical

Examiner

	Plea	se T							E <b>nsure A</b> alth and		-		_	ible.			
For State Registrar			State (	or ivial yie				of De		IVICI		Reg. N	20	เกล	2	39	73
1. Decedent's Nam	e (First, Middl	e, Last)								2.	Date of Dea	ath		, O O	3. Ti	me of De	eath
PATRICK J	. BOWERS										Month 7	2		Year	2 10	23	AM
4a. Facility Name (	If not institution	n, give s	treet and nu	ımber)		4	b. City, To	own, or Lo	cation of Deat	h		40	c. County	of Deat	h		
FRANKLI	n Sou	are	Hos	PITAL	Cente	210	RO		dale			1	396	Tim	100	2	
5. Social Security N 516.34.177		6. Sex	<b>X</b> 2□ F	7. Age (In y	rs. last birth Yı	A A	f Under 1 Nonths		Under 24 Hrs. Hours Min.	. 8.	Date of Birt (Month, Da JAN 19	h y, Year	33	Co	hplace (Sountry) PTH DA		oreign
Usual Residence of				10	O': -										40-l l-ai	de Cit.	Linelan
10a. State	10b. County HARF(	ายา		100.	City, Town o										10d. Insi	de City ]Yes 2	
10e. Street and Nu					MITTE		10f. Zip C	ode				10a C	itizen of \	What Co	untry?		
4202 LITTL						ł	Toi. Zip O	21160				rog. O	USA		GIRTY:		
11. Marital Status		1	2. Was Dec	edent Ever in	U.S.	13. Wa:	s Deceder		anic Origin? (S Mexican, Puert	Specify	Yes or No-	.			rican India	an,	
1 ☐ Never Marr		ried	Armed For 1XXYes If Yes, G Year or D				es, specify Yes 2		Mexican, Puert Specify:	to Ric	an, etc.)		Blac Specif	ck, White y: WH	e, etc.		
(6-2-	15. Deceden	t's Educ	ation					Occupatio			Ī	16b. I	Kind of B	usiness/	Industry		
Elementary/Seco	oify only highes andary (0-12)	si yrado	College (			life. DO	NOT use	retired)	ng most of wor	rking							
12	(Final Adiabata	1 = =4\			CR	RYPT0	LOGIST		. Mother's Nan	/5	vat Middle	Majda	NS NS				
17. Father's Name ROBERT BOV		Lasi)										warde	n Surnan	ne)			
19a. Informant's Na		hin (Tvr	e Print)		19h A	Mailing A	Address (5		LILLIAN : Number or Ru			er City	or Town	State. 2	7in Code)		
MARY MILLE		inp (199	,	IGHTER					HITEFORD				0. 101111	oluto, z	<i>.,p</i> 0000)		
20a. Method of Disp 1XXBurial 2 I 4 Donation	☐ Cremation		emoval from	State	o. Place of D cemetery, VETERA	isposition cremate	on (Name ory or othe	of erplace)	JULY	Date			ocation -		Town, Sta	ite	
	ineral Service GRECOKY	Licens	F.C	M0114	8	22.N F1N 426	lame and K FUNE CRAIN	Address o	Facility OME, P.A S., GLEI	N 51	JRNIE,	MD	210	)61			
23a. Part 1. Enter the		complic	ations that	caused the de	eath. Do no	t enter t	he mode	of dying, s	uch as cardiad	c or re	spiratory ar	rest,			Approx	ximate al Betwe	en
Immediate Cause ( disease or condition resulting in death)	Final	a.	Re	enal		failure								Onset 5 D	and Dea	ath S	
,		(		(or as a cons	a consequence of):  r failure										101	Dai	, <
Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or	nditions, mediate rlying	Ь.			a consequence of):												
that initiated events resulting in death) I		c.	Due to	(or as a cons	eauence of)	:											
		L <sub>d.</sub>															
IE EEMALE.												Т					
IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 □ 9 □ Unknown	months?	23	1 Live	tcome of preg birth 2  Fo nant at time on nown	etal death		ctopic pred ther <i>(sp</i> ec							te of deli	ivery Day	Yea	ar
Part II. Other signif			ributing to d	eath but not r	esulting in th	ne unde	rlying cau	se given ir	n Part I.		23e. Did to	bacco	use cont	tribute to	the cause	e of dea	th?
m eta	stat	TIC	P	nelo	unor	Ma	_				1 □ Y	es 2	2 No	3□ Pr	obably	4 🔲 Unl	known
											24a. Was a autop perfor	SV		Were au prior to d death?	topsy find completion	ings ava	ailable se of
DE 14/22 53-3-11		-									1 ☐ Yes	2 1		1 □ Yes	2 🗆 No	)	
25. Was case referr examiner?  1 ☐ Yes 2 ☐	_	Ho	spital:	Innationt C		ation*	3 🗆 🖂	Other:	. Place of Dea				6 🗆 🗠	or /0-	aif.		
27. Manner of Death			1 ⊿ 28a. Date	Inpatient 2 of Injury	28b. Tim			1	4 ☐ Nursing H	_	5 ☐ Resid				city)		
1 ☑ Natural 2 ☐ Accident	5 Pending investig	ation	(Mon	th, Day, Year)	Inju	ıry	м	: Injury at Work? 1 ☐ Yes	2  No				, 200011				
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi		28e. Place	of Injury - At	home, farm	, street,	factory, o	ffice		28f.	Location (S City or Tow	treet a	nd Numb	er or Ru	ıral Route	Numbe	r,

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760, Physician/Medical Completed by Be မ Certification:

State Registrar

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifiqu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN Square DR Balto, ind DR EDWard C. McCarron 82. Registrar's Signature

**ORIGINAL** 

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D066208

29d. Date signed (Month, Day, Year)

23

21237

DHMH 17 Rev 1/2001

Registrar

08-05598

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 23975

Ronald Wayne Bu			tate of M	laryland	/ Departr	nent of cate of	Health and	Menta	al Hygier			,00 200,
	R	For State eqistrar . Decedent's Name (First, Midd	tlo Last\		Cerun		Death			Reg. I e of Death		3. Time of Death
hysician M∉ Examine		, Decedent's Name (First, Midd Ronald	ne,Last)	Wayr	1e		Bundy		July	nth Da y 22, 2008		0818 hrs
ing Examina		a. Facility Name (if not instituti	on, give stree	t and number		4	b. City, Town, or I	ocation of	Death		4c. County of Dea	
		North Point Boulevar	d / Norris I	_ane			Dundalk	T	- lo 5	ate of District		Birthplace (State or
Funeral	- 1	Social Security Number	6. Sex		ge (In yrs. last t	oirthday)	If Under 1 Year Months Days	If Under Hours	Min		For	eign Country) Maryland
Director		213-42-3251	1_XM :	2 F	63	Yrs.			Aug	gust 6	, 1944	Mar yrand
,		Jsual Residence of Decedent  10a. State 10b. County	,		10c. City, To	wn or Locati	on					10d. Inside City Limits
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ryland a-f sh	휭	10e. Street and Number	Inore				10f. Zip Code			· 10g.	Citizen of What C	ountry?
or 28	Director	7308 North Dak	ota Av	enue				21219			USA	
death with the Maryland or items 23a or 28a-f show must be notified at once.		11. Mantal Status		Was Deceder	nt Ever in U.S.	13. Wa	s Decedent of His es, specify Cuban	panic Orig , Mexican,	in? ( Specify ` Puerto Rican	Yes or No- ı, etc.)	14. Race - An White, etc	nerican Indian, Black,
death or iten	Funeral	1 Never Married 2	Marrieu 1	Yes	2 X No		Yes 2 X No				Specify: Wh	ite
after raf",	2	3 Widowed 4 XD  15. Decedent's Education (Sp	ivorced If Yes	tes:	ompleted) 16	Sa Deceden	t's Usual Occupat	ion (Give l	kind of work d	one 1	6b. Kind of Busine	
hour "natu		Elementary/Secondary (0-12		College (1-4 c		during m	ost of working life	. DO NOT	use retired)	-		
36 thin 72 than than	Completed	7 years				Labo	rer				Construc	tion
215-0036 be filed within 72 hour ntal Hygiene. rked other than "natu ent, the Medical Exan	S	17. Father's Name (First, Midd							's Name (First h Leon		iden Surname)	
121 I be fil ental I arked		Harry William  19a. Informant's Name/Relatio	Bundy	Print \		19b. Mailin	Address (Stree	et and Num	nber or Rural	Route Numb	er, City or Town, S	tate, Zip Code)
D 2 should and M 7 is m	우	Robert Bundy		Brothe:		2515	North S	nyder	Avenu	e, Edg	gemere, M	Maryland 21219
and 2 lealth tem 2		20a. Method of Disposition			20b. Pla		sition (Name of ce		Dat	е	20c. Location - Cit	y or Town, State
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once or other traumatic		1 Burial 2 XCremat		emoval from	State :	iew C	rematory		July 2008	;		e City, MD.
iltim nit. Pa antmes oortan		4 Donation 5 Other 21 Signature of Juneral Servi	ce Licensee		00	22 C	Name and Addres	s of Facility Funer	al Hom	ne Of I	oundalk,	P.A.
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatite event, the Medicin		Inthony	0	nue	lles	7.	110 6011	are P	א חדותי	roan. I	JUHUA I K.P	Approximate Interval
ysician		23a. Part I. Enter the disease, failure. List only one cau	36 OH Cachin	10.			ine mode or dying	, sucii as c	Saldiac of 103	·	.,	Between Onset and Death
Medical Examiner		Immediate Cause (Final disea or condition resulting in death			dominal Injunction							
			b.	to (or as a co	insequence ory.	<u></u>						
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter the denying Carr		to (or as a co	nsequence of):							
	Examiner	(Disease or injury that initiate events resulting in death) La	d C	to (or as a co	nsequence of):							
Ind wied	E	CVCIND FOODILING W. COMM.	d									-
be executed ician and urial - transi	dical	UNPENDED	_ AN	MENDED							23d Date of de	livery
760 icate b g physi		FEMALE: 23c. If yes, outcome of pregnancy b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year										
c 68	ciar	past 12 months?	4		it at time of dea		other (Specify)				10	
cords, P.O. Box 68760 law requires that the death certificate that been signed by the attending physics should be derached for use as the but.	Physician/Me	1 Yes 2 No 9					underlying cause	given in F	Part I	23e. Did to	pacco use contribu	ute to the cause of death?
P.O. es that the igned by be detach		Part II. Other significant cor Artherosclerotic Co				sulting in the	underlying cause	givariii	are i.			Probably 4 Unknown
S, P puires puires an signal of be of	ed t	Artheroscierotic C.	aruiovasco	nai Diseas						24a. Was a		ere autopsy findings available or to completion of cause of
ord aw rec as bee	ple									autops	med? de	ath?  Yes 2 No
certificate t	Completed by						26 Pla	ce of Deat	h (Check only	1 Yes 2	2   100   1	7 165 2 116
Division of Vital Records, tal or attending Physician: The law requints after death.  "A Director: After this certificate has been selled in by the funeral director, page 2 should!	Be	25. Was case referred to me examiner?	Hosp	oital: 1 inc	patient 2	ER/Outpatie		Other <sub>4</sub>			Residence 6 🗸	Other: Scene
of Vil ing Physic After this	₽.	1 ✓ Yes 2 No 27. Manner of Death		28a Date of	Etniury	28b. Time o	f Injury 28c. Ir	ijury at Wo	ork? 28	d. Describe h	now injury occurred n vehicular ac	t cident
OD C anding rr. Aft	tion	1 Natural 5	Pending	FOUND: Jul 22, 20	108	FOUND: 0812 hrs		Yes 2	No No			
ViSic or Atte frer der Directo in by t	Certification:		nvestigation Could not be	28e. Place	of Injury - At ho		reet, factory, office	e building,	etc. 28	f. Location (S or Town, S	Street and Number tate)	or Rural Route Number, City Lane , Dundalk, MD
Div pital o ours af	Serti	4 Homicide	determined		Major Road							
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate t within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be deached for use as the br		29a. Certifier 1 Certifyin	g Physician:	To the best	of my knowledg examination ar	ge, death oco nd/or investig	curred at the time, gation, in my opin	date and ploon, death	piace, and du occurred at th	e to the caus ne time, date	e(s) and manner a and place, and du	e to the cause(s)
To th comp	Medical	29b. Signature and title of ce	an	d manner sta	ited.			nse numbe				d (Month, Day, Year)
	Σ	250. Signature and title of ce	/	Pello			0.0	C.M.E.			July 22, 200	18
1		30. Name and address of pe			e of death (Item	23a)		_				
K		Laron Locke MD.	Assistar	t Medical	Examiner	111 Pe	nn Street, Ba	ltimore,	MD 21201			
S	tate			32 Reg	gistrar's Signatu	ire						
Regis	tra		5 2008 ICME	1500	100 July 1	A PAR	ee.					
DHMH 17 Rev 1/2	2001	·	MINIE			ÖRİĞIN	IAL					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 23976 Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 23, Day 2008 Year 8:45 p. M William Joseph Birmingham, Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Berlin Worcester Atlantic General If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Year) Months Days Hours Min. 11☑ M 2 ☐ F Maryland 29, 1930 Aug. 214-26-0143 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Selbyville 1 □Yes XXNo Delaware Sussex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 19975 38800 Grant Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2XXMarried 1 ☐Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jessie Nordhouse William Joseph Birmingham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Selbyville, Delaware 19975 Gladys R. Birmingham (Wife) 38800 Grant Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 D Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns. 7/26/2008 Middle River, Md. 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lice Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 7922 Wise Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ways on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Revegence disease or condition resulting in death) Due to (or > a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Feta! death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown Part Il Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

Be

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**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a Madical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

7930

attending physician and for use as the burial-transi certificate has been signed by the rector, page 2 should be detached

this

After this funeral of

P.O. Box 68760,

Records,

Division of Vital

Physician/Medical ģ Completed Be Medical Certification: To To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funera

1 Yes 2 No

27. Man r of Death

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

300 Name and address of perso

1 Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 ☐ Could not be

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

5

pleted cause of death (Itemy23a) (Type Print)

29d. Date sighed (Month, Day, Year)

10+ 1 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 8:15 P M 18 2008 July Wyoming Nebraska Carter 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Joseph Richev Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Jan. 1, 1914 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 ☐ M 2XXF Yrs. 10d. Inside City Limits 10b County 10c. City, Town or Location 1 Kontres 2 □ No Baltimore 5 4 1 10g. Citizen of What Country? 10f. Zip Code 21223 USA 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 No Specify: Specify: Black

Month

Day

2008

5. Social Security Number **Funeral** 216-24-4389 Director Usual Residence of Decedent 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD 10e Street and Number 510 N. Stricker Street 11 Marital Status 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Completed by 3 ₩Vidowed 4 □ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Community Healthcare nurse practioner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie Beckett Louise Beckett ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health at Important: If Item 27 is any Injury or other trau 510 N. Sticker Street; Baltimore, Maryland 21223 Michael P. Carter / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 07/24/2008 Crownsville, Maryland Crownsville Vet. Cem 4 □ Donation 5 □ Other (Specify) Wylie Funeral Home, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service License 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one vause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ALZHETHERS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 80/81/1 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown MONDRY EFFUSIONS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Wyoning Carter PERIENSIEN cate has b page 2 sl autonsy performed? 1 Yes 2 No certificate 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ♥Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No al or Attend after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital c within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOREXEL

31. Date filed (Month, Day, Year)

828 EUTHO

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Physician

/Medical

Examiner

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 23<sup>Day</sup> 2008<sup>Year</sup> JULY COLE 2:03P MADELINE 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS 8. Date of Birth (Month, Day Year) 05/28/1936 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country) Days Hours Min 1 □ M 2 🛣 F Months 72 113-26-3663 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo ANNE ARUNDEL ANNAPOLIS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 619 ADMIRAL DRIVE, #202 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **SCHWALB** FELDMAN ANN SAMUEL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2806 CLOVE LANE, EDGEWATER, MD ADAM COLE / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State AHAVAS ISRAEL CONG. 07/24/2008 LIBERTY, NY 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service, License 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2☐NO 3☐ Probably 4 ☐ Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No autopsy 1□ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 28d. Describe how injury occurred 1 Natural 5 | Pendin

**Physician** /Medical Examiner

attending physician and for use as the burial-trar

led by the a detached for

been signed the should be detailed

funeral director,

After this

To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

death.

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

r 28a-f show notified at

rai", or items 23a or Examiner must be r

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death

Pages 1 and 2 should be filed within 72 hours after

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Department of Important: If it any Injury or o

Baltimore, Maryland 21215-0036

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Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FI	EMALE:
23b.	Was decedent pregnant
	in the past 12 months?
	1 Ves 2 Min

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par

	examiner?		Г
	1 Yes	2 No	
7.	Manner of	Death	

6 ☐ Could not be

determined

ry y Ye

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

njury Day Year)	28b. Time of Injury
njury Day Year)	

		1		14010
f	280	. Injury at Work?	-	
N.		1 ☐ Yes	2	□No

28f.	Location	(Street a	nd Numb	er or Ru	al Route

29a.	Certifier	
	(Check on	ł

2 Accident

3∏ Suicide

4 Homicide

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f.	Location (Street and Number or Rural Route in	Numbei
	City or Town, State)	

(Check	ont
one)	

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

State Registrar

31. Date filed (Month, Day, Year) JUL 25 2008

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			For State Registrar	State of N	Marylan		rtment of tificate of	Health and Death	Mental H	ygiene Reg. No. 🔿	000	00074
			Decedent's Name (First, Middle	e, Last)					2. Date of D	eath C	008	3. Cime of Death
	Physici /Medi		Kimberly F.	Day					JULY	23 Day	2008	12:24 P
	Examir		4a. Facility Name (If not institution	, 0	,			or Location of Deat	th	4c. Cou	nty of Death	
	<b>5</b> 1		Baltimore Wash: 5. Social Security Number	ington Medi	cal Ce	nter	Glen B	umie If Under 24 Hrs	8. Date of B		Arund 9. Birtho	ace (State or Foreign
	Funeral Director		213-86-7768	1 □ M 2 <b>X</b> F	44	Yrs.	Months Days			1963	Mary 1	lace (State or Foreign try)
	pu ,		Usual Residence of Decedent			7			05,22,	1505		
	r 28a-f show	'n	10a. State 10b. County		1	, Town or Loc					1	0d. Inside City Limits  1
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	3a or	Ö	2727 Woodland	Avenue				21215			S.A.	,
7	72 hours after death with the Maryland "natural", or items 23a or 28a-f show dical Evarifish must be notified at	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S	6. 13. W	as Decedent of	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or N		Race - Americ	
86	or ite		1 XNever Married 2 ☐ Mari	ied 1 □Yes 2 If Yes, Give	No		□Yes 2 <b>X</b> No		to rileari, etc.)	1	Black, White, e	ack
215-003	hours tural"	ed by	3 Widowed 4 Divorced		s:	16a Dood	ent's Usual Occi	ination			f Business/Inc	
	in 72 n "nat	Completed		st grade completed)		(Give k	rind of work done  O NOT use retire	during most of wo	rking	Tob. Killa o	i busiliess/iii	Justiy
7	d with giene	E	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Testi	ng Techr	ician		Me	dical	
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other than 'amy injury or other traumatic event, the once.	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Na			name)	
Ya	Duid b Ment arkec	ှု	Arthur Day					Florence				
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(e, -)	1 and Healt em 27		Denise Faison / 20a. Method of Disposition	Sister	20b. Pi	2522 S	Shirley ition (Name of	Avenue, I	Baltimor Date	e Mar	<b>yland</b> on - City or To	21215 wn. State
altimore,	ages ent of t: If It y or o		1 Wasurial 2 ☐ Cremation		te į		ition (Name of atory or other pla	i				
華	nit. P artme ortan injur	1	4 ☐ Donation 5 ☐ Other (S		MC.		<b>Lemetery</b> Name and Addi		9/2008	I fort H	egate Au	Maryland
ä	Depar Impo any ir			L c. W	-			4	c. 1		F/H	P.A. 21215
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that can	ed the death	. Do not ente	r the mode of dy	ing, such as cardia	c or respiratory	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Co	20010	10	Andl	towa		`	1	Onset and Death
	Medical	Ш	resulting in death)	Due to (or a	as a consequ	ence of):	11	Control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contro				
	Examiner	<u>_</u>	Sequentially list conditions, if any leading to immediate	b								
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to for a	as a conse <sub>u</sub> u	ence off):						
~	execu n and al-trar	xar	that initiated events resulting in death) Last	c Due to (or a	as a consequ	ence of):						
68760,	ficate be executed physician and s the burial-transit	edical		d								
68	rtifical ng phy as th	Medi	IS SENALS.						5.5			
Box	The law requires that the death certifiate has been signed by the attending age 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom			Ectopic pregnar	ncy		23d.	Date of delive	•
0.	re dea the at ned fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnan 9 ☐ Unknowr	t at time of de		Other (specify)				Month	Day Year
σ.	w requires that the do been signed by the should be detached		Part II. Other_significant condition	ns contributing to death	but not resu	lting in the un	derlvina cause a	iven in Part I.	23e. Did	I tobacco use o	ontribute to the	ne cause of death?
ds,	signe d be	d by	Falue	to Haru			,g g			]Yes 2□N		ably 4 Onknown
5	w requ	Completed	Huguan	161121	10000	Piche	1100 V	100	24a. Wa	s an 24	Ih Were auto	nsy findings available
æ	he law e has	틽		······	.uvc	11010	7	1100	aut	formed? 🦯	death?	psy findings available mpletion of cause of
ta	an: T tifficat tor, pa	Be C	25. Was case referred to medical					26. Place of De		2 TMo	1 🗆 Yes	2 ∐No
>	uing Physician: The Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the In		examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpa	atient 2.21	R/Outpatient	3 □ DOA OI	hor:	lome 5 ☐ Re		Other (Specif	y)
0 0	ng Pl	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, I	njury Day, Year)	28b. Time of Injury	28c. Inji	ury at ork?	28d. Describe	e how injury oc	curred	
<u>8</u> ,	tendi leath. tor: A the fu	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	ation			10000	]Yes 2 □No				
Division of Vital Records,	or At after d Direct in by	Certification: To	4 Homicide determ	ined   28e. Place of I	Injury - At hor etc. <i>(Specify</i>	me, farm, stre	et, factory, office			(Street and No own, State)	ımber or Rura	l Route Number,
-	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director, and the funeral director.		29a. Certifier	g Physician: To the be	st of my knov	vledge, death	occurred at the	time, date and plac	e and due to th	ne cause(s) and	d manner as s	tated.
	e Hos 24 h e Fur	Medical	(Check only one) 2 Medical	Examiner: On the basis and manner	of examinat	ion and/or inv	estigation, in my	opinion, death occ	urred at the time	e, date and pla	ce, and due to	the cause(s)
	vithir vithir To th	Me	29b. Signature and title of certifier				29c. Licer	se number		29d. Date sig	ned (Month,	Day, Year)
	7			`			D	57028		07-	23-0	ぎ
	3		30. Name and address of person	who completed cause of	f death (Item	23a) (Type, P	rint)					
`			Aditya Chor 31. Date filed (Month, Day, Year)	ora M.D.	GOO strar's Signatu	Kidge	ly Aver	nue #231	Anna	polis n	10 71	40)
	Sta Registr			2008	S. S. S.	ure	Es .					
			CULBU		-	.7						

		For State	State of M	larylan		artment o			ental Hyg	ene			
		Registrar  1. Decedent's Name (First, Middle, La	ast)		Cel		Dealli		2. Date of Deat	g. No. 2	108	3. Time of	<u>80</u>
Physicia		Ma	•	Dem	psey				Month July	19,	Year 2008	9:38	РМ
/Medic Examin		4a. Facility Name (If not institution, gir	ve street and number	')		4b. City, Tow	n, or Location	of Death			ty of Death		
		11327 Palatine D					Potomac	_		Mon	tgomen		
Funeral Director			Sex 7.A 1 □ M 2 🔀 F	ge (In yrs.	last birthday) Yrs.	Months Da	ear If Under ays Hours	Min.	8. Date of Birth (Month, Day, September	Year) 18, 191	Corin	lace (State or try)	-
Art. Art.		Usual Residence of Decedent							Depediber	10,171			
anylan show dat	_	10a. State 10b. County		10c. Cit	y, Town or Lo	ecation					1	0d. Inside Cit 1 □Yes	
the Ma 28a-f	Director	Maryland Montgon	nery		Poto	mac 10f, Zip Coo	do		11	Og Citizen o	f What Coun		
3a or		11327 Palatine D	rive				20854		1.	United States			
death	Funeral	11. Marital Status	12. Was Deceden	t Ever in U	.S. 13.	Was Decedent	of Hispanic Or	rigin? (Spe	cify Yes or No- Rican, etc.)				
after or Ite		1 Never Married 2 Married	Armed Forces 1 Yes 2X If Yes, Give			1 ☐ Yes 2 💢			ritouri, ctc./		eify: Whi		
hours tural	ed by	3 X Widowed 4 ☐ Divorced  15. Decedent's E	Year or Dates	:	16a, Dece	dent's Usual Od	ccupation			16b. Kind of	Business/Inc	lustry	
in 72 in "na Medic	Completed	(Specify only highest gi	rade completed)  College (1-4or	· 5+)	ı (Give	kind of work do DO NOT use re	one during mos	st of worki				,	
yd witl giene er tha t, the	E C	Elomoniary/ Cocondary (C 12)	4		Home	naker				Own H			
be file	Be	17. Father's Name (First, Middle, Las							(First, Middle, N		ame)		
hould d Mer marke matic	은	James Arthur  19a, Informant's Name/Relationship	Brown (Type, Print)		19b. Mailii	na Address (Str			elia Ha		n. State. Zip	Code)	
nd 2 salth ar alth ar 27 is		Michael A. Demps				•			Potomac,				
es 1 a of Heg		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 [		1 /	Place of Dispo	osition (Name o	f		ate		n - City or To		
Pag ment ant: I		4 □ Donation 5 □ Other (Spec	rify)			aven Ceme		2008		Silver	Spring,	Marylar	nd
permit. Pages 1 and 2 should be fled within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If tiem 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	ensee	M0130	ar  Ro	Name and Acbert A.	Pumphrey	Funer	al Home/I	Rockvil	le, Inc	00050 0	2005
20200		23a. Part 1. In er the disease, or cor	mplications that cause		150		-		ue, Rockv		aryland	Approximate	
Physician		shock, Inheart failure. List only Immediate Cause (Final	y one cause on each	line.	Myeloma		, 0		, ,			Interval Bety Onset and D Years	eath
/Medical		disease or condition resulting in death)	Due to (or a	-	-	1						. reals	•
Examiner	<u></u>	Sequentially list conditions.	b										
red sit	Examine	Sequentially list conditions, if any, leading to immediate  Cause (Disease or injury	Due to (or a	s a conseq	uence of):								
te be executed ysician and ie burial-transit	Exan	that initiated events resulting in death) Last   C. Due to (or as a consequence of):											
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		_d										
ertifica ing ph e as th	Med	IF FEMALE:											
leath certifica attending ph	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1□Live birth 4□Pregnant	2 🗆 Feta	al death 3	⊒Ectopic pregn ⊒ Other (specif					Date of delive Month		'ear
the de	Physician/Med	1 □ Yes 2 🖾 No 9 □ Unknown	9☐Unknown	at time or t	leath 5L	Other (apecin	y/						
w requires that the d been signed by the should be detached	by Pi	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying cause	e given in Part	l.	23e. Did tob			ne cause of d	eath?
equire een sig ould b									1 □ Y€	es 2 🕅 No	3 ☐ Prob	ably 4 □L	Inknown
has be	Completed				<del></del>				24a. Was a autops	y	prior to co	psy findings a mpletion of ca	available luse of
lcian: The certificate ha										2 X No	death? 1 ☐ Yes	2□ No	
s certific lirector,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital:	tient 2	ER/Outpaties	nt 3□ DOA	Othor:		n <i>(Check only on</i> me 5 <b>⊠</b> Reside		Other (Specif	iv)	
ding Phys h. After this funeral dii		27. Manner of Death	28a. Date of In	jury	28b. Time o		Injury at Work?		28d. Describe ho			<u>y</u> /	
tendin eath. or: Af the fur	catio	1 🖾 Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not I	on			М	1 ☐ Yes 2 ☐						
pital or Attentours after deatheral Director:	Certification:	4 Homicide determined	Zoe. Flace of it	njury - At h etc. <i>(Specil</i>	ome, farm, sti fy)	reet, factory, of	fice		28f. Location (St City or Town		mber or Rura	al Route Num	ber,
spital lours a neral / filled		29a. Certifier 1 X CertifyIng P	Physician: To the bes	st of my kno	owledge, deat	h occurred at the	he time, date a	and place,	and due to the c	ause(s) and	manner as s	tated.	
To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director; to	edical	(Check only 2 Medical Exa	aminer: On the basis and manner		ation and/or ir	vestigation, in	my opinion, de	ath occur	red at the time, d	ate and plac	e, and due t	the cause(s	)
Within Com	Σ	29b. Signature and title of certifier  Poseph M	Hazzin	tom	(i)		cense number				ned (Month,		
,,							32407			July 2	21, 200	ეგ 	
10		Joseph M. Hagge					ter Dri	ve.	#300, Ro	ckvi1	le. Ma	ryland	20850
Sta	ate	31. Date filed (Month, Day, Year)	32 Regis	trar's Signa	ature			,	,				
Registr	rar	.101 2 5 2	008	43. A 1	1. Se	BALL							

08-05520 Daryl Dennis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 23981

		1- For State Registrar	Certif	ficate of De	ath	Reg	). No.	0 2030
Physicia Jedical Exami	in/	1. Decedent's Name (First, Middle,	Dennis			2. Date of Death Month July 18, 200	Day Year	3. Time of Death 0810 hrs
		4a. Facility Name of not institution, Johns Hopkins Hospita	•		ty, Town, or Location of Deat	h	4c. County of Death	VIA
Funeral			. Sex 7. Age (In yrs. last		Jnder 1 Year If Under 24Hr	s. 8. Date of Birth	(MM/DD/YYYY) 9. Bir	
Director		220-84-2048 Usual Residence of Decedent	1XM 2 F 49	Yrs. Mo	onths Days Hours Mi	10-10	-1958 Foreign	untry) MJ
J now any		10a. State 10b. County	J/A 10c. City, To	own or Location	imorl			10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once	Director	10e. Street and Number	1 00	10	Zip Code	10	g. Citizen of What Cou	
eath with the items 23a or ust be notifi		11. Marital Status	12. Was Decedent Ever in U.S.		2120 T			ican Indian, Black,
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she marke event, the Medical Examiner must be notified at once	y Funeral	Never Married 2 Mar Widowed 4 Divor	1 Yes 2 No		pecify Cuban, Mexican, Puert  2 No specify:	o Rican, etc.)	White, etc.  Specify:	lack
hours a	ed by	15. Decedent's Education (Specif			ual Occupation (Give kind of working life, DO NOT use re		16b. Kind of Business/	Industry
5-0036 iled within 72 Hygiene. I other than "	Complet	Elementary/Secondary (0-12)	College (1-4 or 5+)	Self		jed	Home ]	mprovement
nore, MD 21215-0036 ges 1 and 2 should be filed within 72 nt of Health and Mental Hygiene. 1: If item 27 is marked other than other traumatic event, the Medical	Be Co	17. Fathers Name (First, Middle, L	Buise		18. Mother's Nam	ne (First, Middle, M W Den	3 A	25
MD 21 d 2 should Ith and Me n 27 is ma	٩	19a. Informant's Name/Relationshi	(Type, Print) BUISL		ress (Street and Number or	Rural Route Numb		
ore, healt of Healt If item		20a. Method of Disposition  1 Burial 2 Cremation	20b. Pla	ice of Disposition ( matory or other pla	Name of cemetery,	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages 1 an Department of Hea Important: If iter injury or other tra		4 Donation 5 Other Spe 21. 9 g sture of Funeral Service L	uny.	ny Men 22. Name	and Address of Facility   4	1-29-08	Hundall	-
_ ====	9	Duant H	only		LIBERTY H		Be110.1	
Physician 'Medical	9 01	23a. Part I. Enter the disease, or or failure. List only one cause of Immediate Cause (Final disease)	omplications that caused the death. Do n each line. a. <b>Atherosclerotic</b>				st, shock, or heart	Approximate Interval Between Onset and Death
xaminer		or condition resulting in death)	Due to (or as a consequence of):	Cararov	ascular disc.	130		
	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):					
isi _ g & U/	Exam	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					
e executician and	Medical	X UNPENDED	AMENDED 23a,PII,2	7,perME,	g882 8/14/08	TT		
18760, rtificate be ering physiciar as the burial		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 Live birth	ncy 2 Fetal de	ath 3 Ectopic pregr	nancy	23d. Date of deliver	y Day Year
Box 68760, e death certificate by the attending physic cd for use as the but	ıysician/	1 Yes 2 No 9 Unkn	own g Unknown		Specify)			
P.O. es that the gned by the detache	by Phy		ns contributing to death but not resu		ying cause given in Part I.		pacco use contribute to	
ds, F quires en sign uld be		Chronic narco	tism; diabetes me	llitus		Yes 24a. Was a		bably 4  Unknown utopsy findings available
Vital Records, hysician: The law require this certificate has been si I director, page 2 should b	Completed					autops perform	prior to death?	completion of cause of
ital Recician: The	Be Co	25. Was case referred to medical	7		26.Place of Death (Check		2 No 1 Y	es 2 No
Vit.	P P	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 V EF				Residence 6 Othe	er:
ion of tending Pl eath. ior: After the funeral		27. Manner of Death  1 X Natural 5 Pendir 2 Accident Investi	(Month, Day,Year)	8b. Time of Injury	28c. Injury at Work?  1 Yes 2 No	28d. Describe h	ow injury occurred	
Division pital or Attendii ours after death. leral Director: A	ertification:	3 Suicide 6 Could determ	not be 28e. Place of Injury - At home	e, farm, street, fac	tory, office building, etc.	28f. Location (S or Town, St		ural Route Number, City
the Hos hin 24 h the Fun	ledical C	29a. Certifier (Check only 1 Certifying Phy	sician: To the best of my knowledge, iner:On the basis of examination and/					
To witi	Me	29b. Signature and title of certifier	and manner stated		29c. License number	-	29d. Date signed (Mo	onth, Day, Year)
		Yunut ga	thall, ms		O.C.M.E.		July 19, 2008	
0		30. Name and address of person w Pamela E. Southall, MD	no completed cause of death (Item 23 Assistant Medical Exami	•	enn Street, Baltimore,	MD 21201		
St Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature	forke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 24a 27 29a per doc 881 7 25 08 vt. State of Maryland Department of Health and Mental Hygiene for State Registrar Reg. No.2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 19, Day 2008 Year 10:15PMM **Physician** /Medical Charlene Dieter- Hosmer 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 7847 Eastdale Road Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months 1 M 2 F 215-80-0203 48 Yrs Director Jan.4, 1960 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wyddal Event in Count be publified an once. 1 ☑ Yes 2 ☐ No N/A Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code U.S.A. 21224 7318 Conley Street Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Iconis ပ္ Robert Shull 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7318 Conley Street Baltimore, Maryland 21224 Mr. Phillip Hosmer/ Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Oak Lawn Cemetery 7/25/08 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Duda-Ruck F.H. of Dundalk, Inc. 7922 Wise Avenue Dundalk, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) arge cell Physician Bre 4n /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 □ Yes 2 □ No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Mon B Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To pesidence 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one)

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Puneral Director: After this certificate has been signed by the attanding abusing and Division of Vital Records, P.O. Box 68760, icate has been siç , page 2 should b completely filled in by the funeral To the within 2

altimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

NIOHAMMAD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 egistrar's Signature

and manner stated.

RANA, MD, 4920 CAMPBELL BLUK, Balti MD 21336

29d. Date signed (Month, Day, Year)

Carand. M. Jave 40

29b. Signature and title of certifier

29c. License number

D57061

			1- For State of Maryland Registrar		artment rtificate			and M		giene Reg. No	008	23	383
24	DI VIV		Decedent's Name (First, Middle, Last)						2. Date of Dea	ath		3. Time o	
No.	Physici /Medic		W. Pearlie Duncan						July	21, 2	2008 Year	12:0	Ор М
	Examir	er	4a. Facility Name (If not institution, give street and number)		4b. City, To					4c. Co	ounty of Dea		
	Funeral		7426 Village Avenue Apt. 106 5. Social Security Number 6. Sex 7. Age (In yrs. las		If Under 1	Year	ville If Under 2	24 Hrs.	8. Date of Birt	h		rthplace (State	or Foreian
	Director		409-34-2463 1□M 2XF 91	Yrs.	Months [	Days	Hours	Min.	Aug 14	1916	) Mi	rthplace (State country) SSISSIP	pi
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Lo	cation							10d. Inside C	itu Limita
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21215-0036	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual (	Occupa	tion	-6		16b. Kind	of Business	s/Industry	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		Turbunal 2 Dorellation 3 Litellioval Itom State		sition (Name natory or othe		Ł		ate	20c. Local	ion - City or	r Town, State	
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	o the o the o the o the omple	Med	one) and manner stated.  29b. Signature and title of certifier			icense i						th, Day, Year)	
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1	7. Y	-	30. Name and address of person who completed cause of death (Item 23	3a) (Type, F		NU.	2 / 1	14		: 1	2/08		-, ,
Ó	2		Daniel M. Golden, D	.0.	6190	6	earc	ieta	xun B	Ild.		21	784
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 23984 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2008 9:30 a Anna J. Dippel July 18, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 11200 Sheradale Drive Kingsville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 K F 212-01-3593 Aug. 1,1913 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD 1 ☐Yes 2 No Baltimore Kingsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11200 Sheradale Drive 21087 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 TNo Specify Specify: White 3 → Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown Weigelt Marie Haberbusch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda Bankert- Daughter 11200 Sheradale Drive Kingsville, MD 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/21/2008 Holy Redeemer Cem. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 21. Signature of Funeral Service License 6415 Belair Road Baltimore, MD 21206 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inly one cause on each line. Approximate Interval Between Onset and Death 23a. Part . Er er the disease or shock, or heart failure. List Immediate Cause (Final Atheroscleratio disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leauning to influential cause. Enter Underlying Cause (Disease or injury that initiated events July to for as a consequence of resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 ☐Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**Physician** /Medical Examiner

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Examiner

**Funeral** 

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death contificate be executed the ospital o. 44 hours after dea... ~eral Director: After 'in by the fiv within 24 hours aft

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Division or Vital Records, P.O. Box 68760,

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		24a. Was an autopsy performed?  1 ☐ Yes 2 No 1 ☐ Yes 2 □ No 2 No 2 No 2 No 2 No 2 No 2 No 2						
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27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year)  28b. Time of Injury Injury  M  28c. Injury at Work?  1  Yes 2 No	28d. Describe how injury occurred						
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	nysician: To the best of my knowledge, death occurred at the time, date and place niner: On the basis of examination and/or investigation, in my opinion, death occu							

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

on who completed cause of death (Item 23a) (Type, Print)

(Type, Print) A 35522 July 18, 2008 AVENUE BEC AIR MARTLAND 2018

State Registrar

31. Date filed (Month, Day, Year)

JUL 2 5 2008 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month William Herbert Eckstein July 23, 2008 7:20 A. M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**∑** M 2□ F 482-26-4912 Feb. 1, 1931 Iowa Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3210 N. Leisure World Blvd., #1005 20906 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:1953-57 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☒ No Specify: 3 □ Widowed 4 □ Divorced White 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Operations Officer Central Intelligence Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert Eckstein Irene Wridt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue B. Eckstein / Wife 3210 N. Leisure World Blvd., #1005, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ICremation 3 ☐ Removal from State Montgomery Crematorium, Inc. July 25, 2008 Bethesda, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens Robert A. Pumphrey Funeral Home/Rockville, Inc. M00896 BOO W. Montgomery Ave., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or helart failure. List only one cause on each line. Due to (or as a const uence of) arkenson Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2**2** No 1 Tes 3 Probably 4 Unknown 24a. Was an

**Physician** /Medical Examiner

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Examiner

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Baltimore, Maryland 21215-0036

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The law requires that the death certificate be executed burial-transit the as attending nse ρ ed by the a detached f or Attending Physician: the funeral director, After this death. within 24 hours after death To the Funeral Director: l in by t filled the Hospitai

Division or Vital Records, P.O. Box 68760,

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Immediate Cause Imal disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1□Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? res 2 No 1∐ Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

BOIRUSSELL ALEWLE CAITHERS BURG NIN

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 2ď0්8 **Physician** 17:36 Walter H. Ennis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery 5110 Nicholson Lane Kensington If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Vear) Months Days Hours 1 X M 2 □ F 89 August 11, 1918 156~09~0252 New Jersey Director Usual Residence of Decedent 10d. Inside City Limits 10c City Town or Location 10a State 10h County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar invist by inclined at 1 ☐Yes 2 No Director Pehala Park Ocean New Jersey 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 08008 United States 42 Sailboat Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. a filed within 72 hours after of Hygiene al Hygiene. other than "natural", or iter 1 Yes 2 ☐
If Yes, Give
Year or Dates: 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: White Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Fire Department Captain 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Menta Ann Shannon Henry Ennis ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important; If Item 27 Is m any Injury or other traumonce. 9406 Corsica Drive, Bethesda, Maryland 20814 Maureen Ennis George/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven 20c. Location - City or Town, State 20a. Method of Disposition July 25, East Hanover, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Jersey 2008 Cemetery 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda - Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 M0136023a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use es the burial-trans resulting in death) Last Due to (or as a consequence of) Box 68760, pe Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2**X** No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Grocery Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation To the Hospital or Attendle within 24 hours after death,
To the Funeral Director: A completely filled in by the fu death, 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier npleted cause of death (Item 23a) (Type, Print) 301 Name and Adress of person who co Year) istrar's Signature . Date filed (Month, Day, State

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Registrar

State of Maryland / Department of Health and Mental Hygien 2008 23987

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Maryland	2 should I and Meni is marker eumatic		19a. Informant's Na	lame/Relationship (1			19b. Mailin	ng Address (Street	t and Number or Rura	ral Route Numbe	er, City or	Town, State, 2	Zip Code)21901	
	and 2 ealth m 27 i			iller/ dau	ughter ————		47 No	orth East	t Isles Dr	rive No	orth	East, N	Maryland	
Baltimore,	Pages 1 nent of He int: if iten	1	20a. Method of Disp		Removal from State	EV.	rightery offen	sition (Name of matory or other place Uneral		Date V 22.	20c. Loc	cation - City or	Town, State	
Itim	t. Pag rtmenl rtant: njury		° 4 □ Donation	5 ☐ Other (Specify	(y)	Ch	napel-I	Bel Air	200	y 22, 08	Fore	est Hill	l, Maryland	Ĺ
Ba	permit. Departr Imports any inju		1 Hof	real Service Land	M.		Pea	Name and Addre aceful Al _2325 Yor	lternative rk Road T	∋s Funer Timoniu	ral ŝ	Cremat:	ion Ctr.,P. 21093	.A
			Shock, or near	art failure. List only	plications that caused one cause on each lin	ne.	. Do not ente	er the mode of dyin	ng, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between	
	Physician /Medical		Immediate Cause ( disease or condition resulting in death)	on	a Ceresio			acud	ent				Onset and Death	
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Box.	death cer a attendir d for use	Physician/	23b. Was decedent in the past 12, 1 Tes 2	t bigginant	1☐Live birth 2 4☐Pregnant at t	2 Fetal de	death 3□l	Ectopic pregnancy Other (specify)	1		23	3d. Date of deliving Month	ivery Day Year	
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s, P	ang ang bed	by Pi	Part II. Other signifi	icant conditions of	ontributing to death bu	it not resulti	ing in the un	derlying cause giv	en in Part I.	23e. Did to	bacco us	e contribute to	the cause of death?	
ord	w require been sig should b		My	Versian	1 1 1 . 1			<del></del>		1 🗆 Y	es 2	No 3□Pro	obably 4 🗆 Unknown	
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ot	S S D	7: To	1 Yes 2 7	110	1 L Inpatien		R/Outpatient 28b. Time of	3 DOA Othe	4 Nursing Hon				ity)	-
no	tding th. :: Afte	tlon	1 Natural 2 Accident	5 Pending investigation	28a. Date of Injury (Month, Day	Year)	Injury	Work	yat k? Yes 2 ∐No	28d. Describe ho	OW INJuly	OCCUITEG		
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Ö	rs afte el Dir	Cert	4 [   ΠΟΙΠΙΟΙΔΘ	,	building, aic.	(Specify)		-		City or Town			Way F Fa	1
		Medical	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	ysician: To the best of	examination	edge, death on and/or invi	occurred at the timestigation, in my o	ne, date and place, a pinion, death occurr	and due to the c	ause(s) a	ind manner as	stated. to the cause(s)	-
	o the	Mec	29b. Signature and t		and manner state			29c. License				signed (Month,		-
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	6	-	30. Name and addre		completed cause of se			Print)	4	illinor	0 440	1	2000	-
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	Registra		.111	1 2 5 2008		S.	GOGA							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 9:50 JOSEPH AGAN 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAYUEW MEDI (AL CENTER SALLING 17. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. N/A 5. Social Security Number 6. Se TIMORE 8. Date of Birth (Month, Day, Yo Aug. 31, Birthplace (State or Foreign Country)
 Maryland 6. Sex Year) 1919 **Funeral** 1 ☐ M 2 ☐ F 88 212-14-1500 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show s 23a or 28a-f show Edgemere MD Baltimore 1 ☐ Yes 2√2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 21219 U.S.A. 3217 Lynch Road Funeral artment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natural", or Items
Injury or other traumatic event, I'm Medical Express. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 No If Yes, GiveX Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. SpecifyWhite ≥ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+ Trucking Company Truck Driver should be filt.
Alth and Mental Hw.
7 is man 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Tra-Eagan Mary Lang ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3217 Lynch Road Edgemere, Maryland 21219 Mrs. Rose Eagan/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If iter any Injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Holly Hill Mem. Gdns. 7/26/08 22. Name and Address of Facility Duda-Ruck F.H. of Dundalk, Inc. 21. Signature of Funeral Service L 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** INTRACTREBRAL HEMORRHAGE WEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has autopsy certificate 1 ☐ Yes 2 1 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 2 Accident completely filled in by the 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES -2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE BALTIMORE MP LUIS LOPEZ 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Division or Vital Records, P.O. Box 68760,

the Maryland

Baltimore, Maryland 21215-0036

28a-f show

ral", or Items 23a or 28a-f shov Examiner must be notified at "natural", or Items 23a Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23. permit. Pages 1 Department of H Important; If ite any injury or ot once. Physician /Medical Examiner The law requires that the death certificate be executed and physician a the burial-t attending ph has been signed by the e 2 should be detached certificate ha To the Hospital or Attending Physician: After this Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) More tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year) H-0063476 4924 Campbell 15 Baltimore, 1 30. Name who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature 2 5 2008 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 23990 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JULY ESTHER MARIE FIELD 24, 2008 4:00 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 5. Social Securify Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1 M 2 X F 499-07-4499 88 April 4, 1920 Kansas City, Mo. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Harford Bel Air Maryland 1 □ Yes 2X □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 W. Ring Factory Rd. 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes XX No Specify: White XX Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1Elementary/Secondary (0-12) College (1-4or 5+) Housewife Housekeeping-Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gustav Nordvedt Sophie Hovland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James Field (Son) 1120 Emerald Drive Bel Air, Md. 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 刈払 Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith 7/29/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. of Funeral Service License Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 CINSON d disease or condition resulting in death) GRANS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

the death certificate be executed

P.O. Box 68760

Division or Vital Records,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Director

Completed by Funeral

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28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or: any injury or other traumatic event, the Medical Examiner must be n

Baltimore, Maryland 21215-0036

ms 23a or 28a-f shor r must be notified a

the Maryland

Examine

physician and s the burial-trans Physician/Medical attending pl signed by the a þ cate has been sig , page 2 should b Completed certificate has funeral director, Be P After t

To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After filled in by the

State Registrar

(Check only

Signature and title

IF FEMALE 23b. Was decedent pregnantin the past 12 months?

1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 L No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner 1 eath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. atural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

21014

30. Name and address of person cause of death (Item 23a) (Type, Print)

ROBERT DUNCAN 615 W. MACPHAIL ROAD BEL AIR, MD.

31. Date filed (Month, Day, Year) JUL 2 5 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** 10:30 PM 2008 July 20, Evan David Forfar /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery General Hospital Derwood Montgomery If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 04/12/1962 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 **■** M 2 □ F 46 FL 264-71-1474 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, It is Medical Examination to other traumatic event, It is Medical Examination. 1 X Yes 2 □ No Director MD Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20707-United States 615 Montgomery St. Funeral Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Bace - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify. <u>ک</u> Specify: Caucasian 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Art Elementary/Secondary (0-12) College (1-4or 5+) Art Museum Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald Haynie Forfar Carol Deering Trival ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Kennedy/Spouse 615 Montgomery St. Laurel, MD 20707-20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jul 24 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Rapp Funeral & Cremation Services M0038Z Dhunam 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PATOREN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tran to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 □Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖺 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manufer of Death 1 Matural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name address of person who completed cause of geath (Item 23a) (Type, Print) 9 PRINCE PHILIP DP

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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5 2008

32 Registrar's Signature

			1 _ State	State of Man						000	
			Registrar		Ce	rtificate of L	Death	F	Reg. No. 2	800	23992
	Physici /Medic		1. Decedent's Name (First, Middle, Last	Forer	NAN			2. Date of Dea Month	Day	2008	3. Time of Death
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or		th	4c. Cou	inty of Death	
		t in .	Northwest	Hospi		RAND				+1tin	NORR
	Funeral Director			x 7. Age (// XM 2□ F 71	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year)	9. Birthpl Count	lace (State or Foreign try)
	and w		Usual Residence of Decedent  10a. State 10b. County	10	Dc. City, Town or Lo	cation				14/	0d. Inside City Limits
	Maryl -f sho fied a	ţō	MD Baltimore							'	1 □Yes 2 🛣 No
	r 28a r notif	<b>Funeral Director</b>	MD Baltimore 10e. Street and Number		Gwynn O	10f. Zip Code			10g. Citizen	of What Count	try?
	th wit	al D	4120 Villa Nova Road			21207			USA		
	tems er m	nuel	11. Marital Status	12. Was Decedent Eve Armed Forces?		Was Decedent of Hi f Yes, specity Cuba	spanic Origin? (S n. Mexican, Puer	Specity Yes or No-	14. F	Race - America Black, White, e	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※ Divorced	1 XYes 2 No If Yes, Give		1 □ Yes 2 No	Specify:	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1	ecinAfrica	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	edk	15. Decedent's Edu	Year or Dates: 10 <sup>c</sup>		dent's Usual Occupa	ation			America f Business/Ind	an
215	hin 72 an "na Medik	plet	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work done d DO NOT use retired	luring most of wo	rking	TOD. KING O	i business/ing	ustry
7	ed wit /giene er the	Completed	12th	Oollege (1-401 54)	Secur	ity			VA Hos	spital	
n	be file d oth event	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden Surr	name)	
Maryland	hould d Mer narke natic	ပ	Melvin Foreman	- 5.0				an Jones			
S	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hylgiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Ty. Juanita Foreman / Daugh	,		g Address <i>(Street a</i> South Laure					Code)
ē,	s 1 ar f Hea item 2		20a. Method of Disposition			sition (Name of natory or other place				on - City or Tov	vn. State
E	Page nent o nrt: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval nom State	Metro Cran				Baltim	-	
Baltimore,	mit. spartn porta y Inju		21 Supraire of Funeral Service License			. Name and Address					alto Co
<u> </u>	83568	1	Mandon,	V.ally	10 9	200 Liberty	7 Rd. Rand	allstown, N	1D 21131	3	110.0.
г			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the ne cause on each line.			g, such as cardia	c or respiratory arr	est,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	LUNG	CA	ncer					Onset and Death
	Examiner		Toolaing in docum	Due to (or as a co	onsequence of):						
Ļ		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):						
1	cuted id ansit	Examiner	Cause (Disease or injury that initiated events								
Š,	e exerian ar		resulting in death) Last	Due to (or as a co	insequence of):						
09/89	ficate be executed physician and is the burial-transit	edical	d								
Š S	ding p	/Me	IF FEMALE:	3c. If yes, outcome pf p	roananav						
ROX	death certi e attending id for use a	cian	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)				Date of deliver Month	y Day Year
j.	t the d by the ached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	o or death 5	Other (specify)					
ν, T		by P	Part II. Other significant conditions con	tributing to death but no	ot resulting in the un	derlying cause giver	n in Part I.	23e. Did tob	oacco use co	ontribute to the	e cause of death?
ecords,	equire en sig ould b							1 □ Y€	es 2∏ No	3 Proba	bly 4 ∐Unknown
(1)	law r las be 2 sh	Completed						24a. Was a		b. Were autop	sy findings available
	the cate h	5					<del>.</del>	autops perforr 1□ Yes 2	ned? 2 No	death?	pletion of cause of
vitai	certifi	Be	25. Was case referred to medical examiner?	ospital:				th (Check only on	<u> </u>		
0	Phys r this ral dii	<u>۹</u>	1 Yes 2 No □	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatient 28b. Time of		_ 4 □ Nursing H	ome 5 Reside			
0	th. :: Afte e fune	ij	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea	ar) Injury	28c. Injury Work? M 1 1 7	es 2 □ No	28d. Describe ho	w injury occ	urred	
VISION	Atter	Eg	3 Suicide 6 Could not be determined	28e. Place of injury -	At home, farm, stre		20.10	28f. Location (St	reet and Nur	mber or Rural	Route Number
5	rs after or ral Dir	Certification:	- Tomicide	building, etc. (S	респу)			City or Town	, State)		
	I or ne repostral or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	Medical	Check billy 2   Wedical Examin	ician: To the best of my	y knowledge, death mination and/or inv	occurred at the time	e, date and place	e, and due to the ca	ause(s) and	manner as sta	ited.
:	o the o the omple	Med	29b. Signature and title of certifier	and manner stated.		29c. License					
1	- s - ō		· Castel	Physic	iAN				Date sign	ned (Month, D	ay, rear/
	d	-	30. Name and address of person who cor	-			SYTS	0 ,	1017	· T	21133
	V		FEDERICK B.	IRKC, Ja		5401	old	LOURT RO	oad f	LANDAI	IsTumm, mo
	Stat Registra	_	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature						

			1 - State of Mar Registrar	yland / D	epartment of F Certificate of I	lealth and M Death	lental Hyg	leg. No. 20 (	08 23993
	Physicia	an	1. Decedent's Name (First, Middle, Last)				Date of Dea     Month	Day Y	3. Time of Death
	/Medic	al	Sarah B. Footman  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	07	18 20 4c. County of	008 9:00 P
	Lxaiiiii		Futurecare - Homewood	_	Be	altimore   If Under 24 Hrs.			
	Funeral Director		216-28-3302 1□M 3√2 F	(In yrs. last birth	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day FEb. 10,	Year) 1927	9. Birthplace (State or Foreign Country)
	/land		Usual Residence of Decedent  10a. State 10b. County 1	0c. City, Town	or Location				10d. Inside City Limits
	e Mary Ba-f sh	ctor	MD		Baltimo	re			1∏Yes 2☐No
	s I and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. I them 21 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Event in a cust be retified in	<b>Funeral Director</b>	10e. Street and Number 509 N. Pulaski Street		10f. Zip Code 212	223		log. Citizen of Wh	
	filed within 72 hours after death wi ail Highen than "natural", or items 23a other than "natural", or items 23a vent, tha "Madical Even in or items	nue	11. Marital Status 12. Was Decedent Ev. Armed Forces?	er in U.S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, White, etc.
9500-c	urs aft al", or Extri	ρ	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 ⊡Yes 2,52 No	Specify:		Specify:	Black
2	72 ho "natur dical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. I	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of worki	ing	16b. Kind of Busin	ness/Industry
7 7	filed within Hygiene. other than sent, the man	dmo	Elementary/Secondary (0-12) College (1-4or 5+)		custodian	1)		Baltim	ore City
	be filed tal Hyg d other	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle,	Maiden Surname)	
<u>y</u>	should be figured by the stand Mental I is marked of umatic ever	ပ္	Henry Epps				uise Murr		70.0010
Š	and 2 sho ealth and n 27 is ma ner trauma		19a. Informant's Name/Relationship (Type. Print) Serrina F. Boone / Daughter		Mailing Address (Street 8 Carveliard				
ce,	es 1 and 2 of Health Fitem 27 r other tr		20a. Method of Disposition		Disposition (Name of crematory or other place			20c. Location - Ci	
Dallimor	t. Pag tment tant: It jury o		1 XXSurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	MD Natio	onal Cemetery  22. Name and Addres	07/26/		Laurel, Man	•
מ	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee			ilmor Stree			
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do no	ot enter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
F	hysician	9 17	Immediate Cause (Final disease or condition resulting in death)		NIETHA				Onset and Death SIX MON THS
est.	/Medical Examiner		Due to (or as a d	consequence of	f):				
7	D ±	iner	Sequentially list conditions, if any conditions, if any cause. Enter Underlying Cause (Disease or injury	consequence of	fi:				
/	xecute and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C	consequence of	f):				
00/0	icate be executed physician and the burial-transit	edical E	d						
0 1	ertifica ding ph e as th	Med	IF FEMALE:						-
	To the hospital or tending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	hysician/M	23c. If yes, outcome of the past 12 months?  1 \( \text{Yes} \) 2 \( \text{NN} \) No \( \text{P} \) Unknown	Fetal death	3 Ectopic pregnanc 5 Other (specify)	У		23d. Date Monti	,
֓֞֞֜֜֜֜֜֜֜֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	s that t ined by e detac	by Ph	Part II. Other significant conditions contributing to death but			en in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
Solo	equire sen sig ould b		KESTING IONLY	ALLU	ent		1 🗆 Y	es 2 □ No 3	Probably 4 Unknown
	Pnysician: The law r this certificate has be ral director, page 2 sh	Completed					24a. Was a autops perfor	sy pri- med? de:	ere autopsy findings available or to completion of cause of ath?
ַ    -	certific ector,	Be (	25. Was case referred to medical examiner?  Hospital:		Other	26. Place of Death	(Check only or	ne)	
5 7	y Pnys er this eral dir	٦: <u>۱</u>	27. Manner of Death 28a. Date of Injury	28b. Ti	me of 28c. Injur	v at		ence 6 Other	
5 :	ath. or: Affe he fun	atio	1 Natural 5 □ Pending (Month, Day, 1 2 □ Accident investigation	<i>(ear)</i> Inj	ury Worl M 1 □	<br Yes 2□No			
֡֟֝֟֝֟֓֟֝֟֓֓֓֓֓֓֓֓֓֟֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	ral or Atti	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	- At home, farn (Specify)	m, street, factory, office		28f. Location <i>(S</i> City or Tow	treet and Number n, State)	or Rural Route Number,
K	n 24 hour n 24 hour ne Funer pletely fill	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of Medical Examiner: On the basis of eand manner state	xamination and					
	Vith:	Ž	29b. Signature and tiple of certifier	mo	29c. Licens	w745	2	29d. Date signed (	(Month, Day, Year)
•	10		30. Name and address of person who completed cause of deal Thene Zes During	th (Item 23a) (T	ype, Print) 250 Wilk	tens Au	K #30	Apatto	-3-2008 o. M. 21229
	Stat		31. Date filed (Month, Day, Year) 32 Registrar's	Signature	Lasti				
	Registra	ar	JUL 2 5 2008	100					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2008 23994 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician EDWARD** JULY 2008 FRIEDMAN 8:03A /Medical 4a. Facility Name (If not Institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 11 M 2 □ F 9. Birthplace (State or Foreign Country) 8. Date of Birth Month, Day, Year) 04/20/1951 **Funeral** 7. Age (In yrs. last birthday) 213-58-9138 57 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examired Installed at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 1 □Yes 2 No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 OLD HOUSE COURT 21208 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕽 No WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ ATTORNEY AT LAW LAW Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JACK FRIEDMAN DIANE MARGOLIS ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 OLD HOUSE COURT, PIKESVILLE, MD HELEN FRIEDMAN / WIFE 20b. Place of Disposition (Name of cemeter, Stephalery of other place)
MEMORIAL PARK 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 07/24/2008 RANDALLSTOWN, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Par 1 Ent 1 the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh 2, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, d any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lius to (or as a consequence of) requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No Completed 3 Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 No 1 □ Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.
To the Funeral Director: After this certifica 1 ∐Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) Will 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6/101 RWSON . Date filed (Month, Day, Year) State 32 Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760,

Records,

Vital

of

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Leda L. Garrett /Medical Julv 24 2008 9:03 a M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs.

Months Davs Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
Dec. 15,1921 6 Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months Days 1 M 2 SF Director 86 213-18-8648 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be radified at angles. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Penn. York 1 ☐ Yes 2 ☑ No Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 425 Westminster Ave. Cottage Funeral 83 17331 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □Yes 2√ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☐ No Specify 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) never worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Arthur Albert Garrett Anna Mary Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17331 19a. Informant's Name/Relationship (Type, Print) Ruth Calp - sister 425 Westminster Ave. Cottage 83, Hanover, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State Trinity U.C.C, Cem. July 28,2008 Manchester, MI. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P. . . Hent Elle 3296 Charmil Dr. Manchester, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Coli URMANY infection with systemic Inflammatory disease or condition resulting in death) ineeh /Medical Due to (or as a consequence of): Response Suncrom Examiner e aquantiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be execute and Due to (or as a consequence of) attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year P.O. ed by the a detached f 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has page autopsy certificate performed 2 **2** No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 【☐ Other (Specify) Hospital: 1 Tes 2 No Certification: To After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) JUL 25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

213

29b. Signature and title of certifier



29c. License number

D31660

LUESMINSTER

29d. Date signed (Month, Day, Year)

07 24 2008

marylad 2115

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 19, 2008 12:05 P M **Physician** Elizabeth Mary Goldsmith 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery **Examiner** Bethesda 9205 Cedar Crest Drive 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Y If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 1925 South Dakota 5. Social Security Number Days Hours **Funeral** 82 1 □ M 2 👿 F 468-22-3997 Director 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10b County show 1 □Yes 2xxXVo ss 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. I them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be rediffied at Bethesda Director Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20814 9205 Cedar Crest Drive 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status White 1 ☐ Yes 2 🛣 No 1 ☐ Never Married 2 ☐ Married Specify: Baltimore, Marvland 21215-0036 2 3 ☐ Widowed 4 🎇 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Health Care Nutritionist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith J. Oretli George Albert Cassutt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11309 Stryver Court, North Potomac, MD 20878 19a. Informant's Name/Relationship (Type. Print) George P. Goldsmith/Son Pages 1 and 2: July 22, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Montgomery Crematorium, Inc. permit. Pages Department of Important: If It any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2008 Bethesda, MD 22. Name and Address of Facility Colert A. Pu Bethesda-Chevy Chase, Inc. Bethesda, MD 20814 Pumphrey Funeral Rome/ c. 75 7 Wisconsin Ave. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee M01346 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death つわつい Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Examine The law requires that the death certificate be executed the attending physician end hed for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23d. Date of delivery 23c. If yes, outcome of pregnancy Live birth 2 Fetal death Year 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 T Ectopic pregnancy Month 5 Other (specify) 9 Unknown 9 ☐ Unknown as been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown of Vital Records, à Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 1 □ Yes 2/No certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No After this c Certification: To 28d. Describe how injury occurred 28c. Injury at Work? Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death or Attending Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number ature and title of certifie Jul 22 2008 mo Dont Paik

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRECKER, MO DIME

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Ralph Warren Goodman 2008 9:48 July 14 /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery <u>324A Southampton Drive</u> 8. Date of Birth (Month, Day, June 20, 9. Birthplace (State or Foreign Country) 1945 Pennsylvania 5. Social Security Number Age (In yrs. last birthday) If Unde **Funeral** Days Hours 1**X** M 2 □ F Months 63 June Director 172-36-2431 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County iral", or items 23a or 28a-f shov Examiner must be notified at 1 □Yes 2 No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20903 324A Southampton Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Myes 2 No
If Yes, Give
Year or Dates: Vietnam 1 X Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2 ☑No Specify. Specify: White ģ 3 Widowed 4 Divorced 'natural' Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Bill Collector Credit Union 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Edgar Goodman, Jr. Phyllis Reese ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Gregory Shannon / Cousin Silver Spring, Maryland 20906 3421 Beret Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date jo <u>--</u> ö 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Montgomery Crematorium, Inc. July 28, 2008 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 W. Montgomery Ave. Rockville, Maryland 20850 21. Signature of Funeral Servi License M00896 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final yem **Physician** CORDINAY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed I physician and s the burial-trans Due to (or as a consequence of): Physician/Medical cate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? (es 2) No 1 ☐ Yes **Division of Vital** director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Attending 1 Natural 5 Pending investigation To the Hospital or Attendli within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗺 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 050086 person who completed cause of death (item 23a) (Type, Print) 12201 Plum Orchard Drive, Silver Spring, MD 20904 Jeffrey We 31. Date filed (Month, Day, M.D. Wetstone, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 2008 GORI MARY D. 11:00a™ 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Larkin Chase Bowie Prince George Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
March 14,1918 Pennsylvania Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2 K F 90 Yrs 195-26-6918 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Pasadena Anne Arundel Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21122 1515 Marco Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 2 No White 1 ☐ Yes 2 No Specify Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Josett Manufacturing Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Krupa Marianna Smith Stanley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1515 Marco Drive, Pasadena, Maryland 21122 (Daughter) Susan Julian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 DRemoval from State Bethlehem, Pennsylvania 07-28-08 Holy Saviour Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility. McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Funeral Service License 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only on cause on each line. Approximate Interval Betweed Onset and Death Nonet and Dodle Importing diate Cause (Final direase or condition esulting in death) -al 010 Due to (or as a consequence of): MONTH HUDMIL Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner musit be notified at any Injury or other traumatic event, the Medical Examiner musit be

Baltimore, Maryland 21215-0036

use as the burial-trans and nding physician atter signed by the a peen has

death certificate be executed

P.O. Box 68760.

Division or Vital Records.

Physician/Medical þ Completed 25. Was case referred to medical examiner? Be

Examine ို funeral 27. Manner of Death Certification: To the Hospital or Attendlr within 24 hours after death.

To the Funeral Director: After completely filled in by the fur

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

9 Unknown

1 ☐ Yes

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

2 No

5 ☐ Pending

investigation

determined

6 Could not be

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 No 3 Probably

23e. Did tobacco use contribute to the cause of death?

4 □Unknown

24a. Was an autopsy performed? Yes 2 No 1 Yes

1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certific

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 MITCHIL Nader

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JULY 22 Day **GENDINA** 2008 10:20P M KLARA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** CounRUSSIA Months Days Hours Min 0371871924 219-41-5525 84 Director Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, It. Medical Exa. Illust Instal De notified at Director MD N/A X□Yes 2□No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 6938 BROOKMILL RD., APT. 2D 21215 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: If Yes, Give Year or Dates 2 Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PHYSICIAN MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LAZAR GENDIN ၉ REVEKKA LYKOVSKAYA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MIKHEL KORKH / HUSBAND 6938 BROOKMILL RD., APT. 2D BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HAR SINAI CEMETERY 7/24/2008 OWINGS MILLS, MD uneral/Service vir en 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, nset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) n yuem /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) physician Box 68760. Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a o 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u></u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown s peen s Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s certificate of Vital 1 □Yes 2 🗷 No 2 🗆 No 1 🗆 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical 26. Place Death (Check only one) Hospital: Other: 1 Yes 2 1€ No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 □Yes 2 □No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of mp 30. Name and Nwho completed car of death (Jem 23a) (Type, Print) 1838 Green Tree Rd # 300 ltt (emu llen 31. Date filed (Month, Day, Registrar's Signature Year, Registrar

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7	/Medio ~-∢ Examin		4a. Facility Name (If not institution, g	ive street and number)	011	4b Cjty, Town, o	or Location of Death	zurg	4c. County of Dear	
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×	Funeral		5. Social Security Number 6.	Sex 7. Age (lir	yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 10/04/1	Year) 9. Bir	thplace (State or Foreign ountry)
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200	r iter	Funeral	11. Marital Status  1 □ Never Married 2 □ Married	Armed Forces?	1110.0.	If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Black, Whit	
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<u>√2</u>	filed within Hygene. other than '	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Pa	life. DO NOT use retire	0)		Parety	Ation
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Maryland	2 should and Mei is marke aumatic		19a. Informant's Name/Relationship	(Type. Print)	19b.	Mailing Address (Street	and Number or Ru	ral Route Numbe	r, City or Town, State,	Zip Code)
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Baltimore	ges 1 nt of H if ite or ot		20a. Method of Disposition 1 Deurial 2 Cremation 3	☐ Removal from State	20b. Place of I cemetery	Disposition (Name of crematory or other pla	ce)	Date	20c. Location - City or	Town, State
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	-		23a. Part I. Enter the disease, or co	mplications that caused the	death. Do no	ot enter the mode of dyi	ing, such as cardiac	or respiratory an	rest,	Approximate Interval Between
10	Physician		shock, or heart failure. List on Immediate Cause (Final disease or condition	ly one cause on each line.	11/5	CANCE	'n_			Onset and Death
	/Medical		resulting in death)	a.  Due to (or as a co	onsequence of	n:				
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Box	ath ce ittendi or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐	Fetal death	3 Ectopic pregnan	су		23d. Date of de Month	elivery Day Year
P.O. I	he de / the a	ysic	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at tim 9 ☐ Unknown	ne of death	5 ☐ Other (specify) _				,
σ.	ilcian: The law requires that the discertificate has been signed by the rector, page 2 should be detached		Part II. Other significant conditions	contributing to death but no	ot resulting in	the underlying cause give	ven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
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Division of Vital Records,	ding Physician: The In. After this certificate hit funeral director, page		1 ☐ Yes 2 ☑ No 27. Manner of Death			Datient 3 DOA			ence 6 Other (Spe	ecify)
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İSİ	I or Attene after death Director: I in by the	fica	3 ☐ Suicide 6 ☐ Could not	he l	At home, farr	n, street, factory, office		28f. Location (S	treet and Number or F	Rural Route Number,
ρi	s after s all or all Dire	Certification: To	4 ☐ Homicide determine	building, etc. (8	specity)			City or Tow	n, State)	
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	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: Atten this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the temporal process.	Medical	one) 29b. Signature and title of certifier	and manner stated		29c. Licens			29d. Date signed (Mon	
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	2		30. Name and address of person wh	o completed cause of death	n (Item 23a) (1	ype, Print)	, . ,	\	M7 24,	~~
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	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	MIL				